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# **Victoria Rose Paul**

## INVESTIGATION REPORT

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**Prepared By**  
**Nadine Cooper Mont**

May 24, 2012

This report and the independent investigation that preceded it was ordered by Justice Minister Ross Landry pursuant to Section 7 of the *Police Act* on August 25, 2011.

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May 15, 2012

The Honourable Ross Landry  
Minister of Justice  
Nova Scotia Department of Justice  
5151 Terminal Road  
P. O. Box 7  
Halifax, Nova Scotia B3J 2L6

Dear Minister,

Pursuant to your Ministerial Order of August 25, 2011, please find enclosed the report and recommendations regarding my investigation of the circumstances pertaining to Ms. Victoria Rose Paul's involvement with the Truro Police Service. Also included is my review of the adequacy of the subsequent investigation conducted by Halifax Regional Police.

I am hopeful that the work I and my investigative team have done will assist both provincial and municipal levels of government in making improvements to the lock-up system in Nova Scotia. While we will never eradicate in-custody deaths, it is my hope that other families can be spared the anguish experienced by Victoria's family and the Mi'kmaq community in general.

If you require any clarification, please do not hesitate to let me know.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Nadine Cooper Mont', with a large, stylized flourish extending upwards and to the left.

Nadine Cooper Mont  
Victoria Paul Investigation

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Katu wla: eliaq ketlewey aqq nepisimk  
Towards Truth and Healing

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## Acknowledgements

I want to acknowledge all the assistance I have had in investigating this matter and preparing this report.

First of all, I want to thank the Minister of Justice for giving me the opportunity to do this. It has been a great privilege to make a contribution toward improving policing in this province in even a small way.

Next I must acknowledge the work of my investigators Jennifer Innis and Tony Penney, who spent an incredible number of hours preparing for and conducting interviews as well as meticulously recording the evidence used in the report. I also want to thank Jean McKenna for her legal opinions and contributions, which were always timely and on point. But I must be clear that the conclusions and any errors are mine and mine alone.

Deborah Maloney was appointed by the Minister as a native observer. She was so helpful to all of us in helping us understand Mi'kmaq culture and the concerns of the community and the family. I feel privileged to have had the opportunity to meet her. I have learned so much from her.

My thanks to the Paul family for their time and patience through another process in finding answers to what happened to their loved one, Victoria Rose Paul. Their strength and perseverance is admirable.

I also want to thank the Truro Police Service and their Chief, David MacNeil. Their openness and cooperation was exceptional. Inspector Rob Hearn, who was given the task of assisting us, was extremely helpful. The Halifax Regional Police were equally as open and co-operative, and Superintendent Don Spicer and his team were great to work with.

Cheryl Maloney, executive director of the Native Women's Association, who led the request for this investigation, was very helpful to us in communicating with the family and the community and in making sure we understood the issues facing native women in Nova Scotia.

Finally, thank you to all my staff at the Nova Scotia Office of the Police Complaints Commissioner, who had to put up with my focus being elsewhere the last nine months.

## Background Information

On August 27, 2009, Victoria Rose Paul was with her son, Deveron Paul, in the Town of Truro. Deveron Paul had recently been released from a federal correctional facility and was on conditions. Victoria and Deveron took Deveron's son to the local exhibition for the day, and then after returning him to his maternal grandparents, Victoria and Deveron went to a friend's home and then went to a local bar known as the Warehouse, located in the downtown core of Truro.

An incident in the bar resulted in Deveron and Victoria being escorted out of the establishment. Once they were outside, Cst. Monica Garland (formerly of Truro Police Service), who was on site regarding another matter, approached the Pauls to see if everything was all right. She was informed by the bouncers that Deveron may be on conditions and that he may have something concealed in his pants. Cst. Garland requested assistance, and subsequently the Pauls were arrested pursuant to Section 87(1) of the *Liquor Control Act* for being intoxicated in a public place.

Both Deveron and Victoria were booked and placed in cells in the Truro Police Services' (TPS) lock-up facility around 3:15 am on August 28, 2009. Once placed in cell 7, Victoria settled relatively quickly and went to sleep. Around 6:17 am, Victoria started to exhibit behaviours that were not consistent with the previous three (3) hours, and was rolling around on the bunk. She fell off of the bunk onto the floor and continued to move around as if in distress. When asked if she was all right by the custodian, she advised she was not.

Victoria suffered an ischemic stroke while in Truro police custody. She was not medically assessed or transported to the Colchester Regional Hospital until after 1:00 pm. Victoria was later transported to the Queen Elizabeth II Health Science Centre (QEII), where she was placed on life support. Victoria's family took her off life support and she passed away on September 5, 2009.

Chief David MacNeil, of TPS, learned of Ms. Paul's failing medical status and transfer to the QEII in Halifax through media reports. Chief MacNeil telephoned Deputy Chief Chris McNeil of Halifax Regional Police (HRP) and requested an operational review of the incident. Superintendent Don Spicer was tasked to head the team who went to Truro and conducted the review. A report was submitted, which contained their findings and recommendations.

Victoria Rose Paul was a Mi'kmaq from the Indian Brook reservation. She was a single mom to her only child, Deveron Paul. Family and friends described Victoria as someone full of life, loved her son and grandson, had a smile that would light up



a room, and a laugh that was contagious. My deepest sympathies are extended to the Paul family for the loss of their loved one and for the difficult time they have had in dealing with Victoria's death and trying to find answers.

As well, I acknowledge the strain this has put on officers of Truro Police Service, for they have been under professional and public scrutiny for this matter for over two (2) years.

## **Terms of Reference**

On August 25, 2011, the Honourable Minister of Justice, Ross Landry, pursuant to Section 7 of the *Police Act*, appointed me, Nadine Cooper Mont, to conduct an independent investigation of the circumstances pertaining to Ms. Victoria Paul's involvement with the Truro Police Service, as well as the adequacy of the subsequent investigation conducted by the Halifax Regional Police.

The order states as follows:

*AND WHEREAS the public, Ms. Paul's family and the Aboriginal community, including the Nova Scotia Native Women's Association, have expressed concerns to the Minister of Justice and the Premier, who is the Minister responsible for Aboriginal Affairs, and have requested an independent process to review the actions of the Truro Police Service.*

*AND WHEREAS in February, 2011 a resolution supporting an inquiry into the detention of Ms. Paul was passed by the Atlantic Policy Congress of First Nations Chiefs.*

*AND WHEREAS the Minister of Justice has determined that an independent investigation of the circumstances of Ms. Paul's arrest, confinement and transfer to hospital is appropriate in the circumstances.*

*IT IS HEREBY ordered, in accordance with Section 7 of the Police Act, which allows the Minister of Justice to order an investigation into any matter relating to policing and law enforcement in the Province, including an investigation respecting the operation and administration of a police department, that Nadine Cooper-Mont conduct an investigation and provide a written report to me, with recommendations if they are deemed appropriate.*

On September 7, 2011, two experienced investigators, one civilian and one a retired RCMP officer, were appointed by the Minister under Section 7 of the *Police Act* to assist me in the investigation. Ms. Jennifer Innis was seconded from the Nova Scotia Office of the Ombudsman and designated the lead investigator. Mr. Tony Penney, a retired RCMP officer, is an investigator with the Nova Scotia Office of the Police Complaints Commissioner.

Ms. Deborah Maloney was appointed under Section 7 of the *Police Act* as the Mi'kmaq observer to provide advice and information to the team regarding the Mi'kmaq culture and their experiences within the justice system. Ms. Maloney is currently a Corporal with the RCMP.

Ms. Jean McKenna, a former vice chair of the Nova Scotia Police Review Board and legal counsel to the Bailey Inquiry (2005), was appointed legal counsel to the investigation. These appointments are set out in Appendix A.

My background and the backgrounds of my team members are set out in Appendix B. An extension for the investigation was requested on February 10, 2012, and was granted by letter on February 23, 2012, until June 1, 2012.

Once the team was assembled, meetings were held with TPS, the Police Association of Nova Scotia (PANS), HRP, the Paul family, Ms. Cheryl Maloney of the Nova Scotia Native Women's Association, and respected members of the Mi'kmaq community. In these meetings, I outlined how I intended to carry out this investigation, discussed any concerns, and listened to suggestions individuals may have had regarding the process. I also provided clarity with regard to the terms of reference. I promised all the participants fairness, thoroughness, and transparency (as far as possible given our mandate). I believe we have done that.

Once these meetings were completed, we determined a plan for the investigation and interviewed relevant individuals who came in contact with Victoria Rose Paul that evening and day, as well as individuals having a direct or indirect responsibility for relevant legislation, regulations, policies, and standards referred to in the terms of reference. A list of those interviewed and their positions are set out in Appendix C.

My team and I have spent time in the community of Indian Brook, spoken with elders and friends and family of Victoria Rose Paul, met with various individuals and agencies involved with the Mi'kmaq community, and participated in training regarding aboriginal perspectives, history, and experiences in the justice system. Our lead investigator also participated in some aboriginal ceremonies, such as a native sweat and smudging, as part of her aboriginal perceptions training. These interactions and experiences, as well as the many conversations with our Mi'kmaq observer, Ms. Maloney, have exposed me to a rich and complex view of aboriginal people.

The stories and challenges of residential schools, loss of traditional ways and language, addictions, poverty, and a sense of community values that are different from mainstream society have had an impact on aboriginals that is staggering. The Paul family has not escaped the impact of these challenges.

Following consultations with the Paul family and Ms. Cheryl Maloney, the Ministerial Order identified the following issues as the scope of the investigation:

- *Whether the Truro Police Service complied with all appropriate training, policies, procedures, guidelines, Nova Scotia statutes and regulations, and the Criminal Code (Canada) in relation to the events of August 28, 2009, from the moment Victoria Paul was arrested and detained for public intoxication to the time an ambulance arrived to respond to Ms. Paul;*
- *Whether the Truro Police Service provided appropriate monitoring of Ms. Paul's health and access to a medical assessment in a timely manner;*
- *Whether the Truro Police Service appropriately communicated with Ms. Paul's family having regard to all appropriate training, policies, procedures and guidelines;*
- *Whether the Truro Police Service policies, procedures and guidelines relating to the manner in which it detains, monitors and responds to intoxicated persons, are adequate; and*
- *Whether the investigation by the Halifax Regional Police into Ms. Paul's death was adequate, performed faithfully and impartially, and free of actual or perceived conflict of interest or bias.*

Victoria's family and the Mi'kmaq community want to know the following:

- Why was medical attention not provided sooner to Victoria?
- Why was Victoria left to lie on the cell floor in her urine?
- Was there anything criminal that took place?
- Was Victoria treated in this manner because she was Mi'kmaq?

## Investigative Principles

It is important for the reader to understand the context of the investigation and the structure of this report. This investigation is grounded in the principles of natural justice, simply meaning that the process encompasses procedural fairness and is conducted by an impartial decision maker. In the interest of full disclosure, Ms. Cheryl Maloney of the Nova Scotia Native Women's Association is a cousin of Ms. Deborah Maloney, the Mi'kmaq observer appointed by the Minister. All individuals involved had an opportunity to present their side of the facts, and I as the decision maker have weighed the evidence in a balanced and impartial manner in which there was no favour granted to one side over another.

I find the evidence speaks for itself, and as a natural flow from the facts, findings have been made, which then lead to recommendations. Findings and recommendations are set out at the conclusion of this report.

I have adopted as a guideline the following sentiments from the Honourable Judge Anne Derrick, who presided in the matter of a fatality inquiry regarding the death of Howard Hyde while in custody of the Province, Halifax, Nova Scotia (2010):

*First of all, the principle of fairness that must characterize any inquiry requires that hindsight be applied appropriately, to recommendations, which must be forward-looking, and not to the actions (or inactions) and decisions that were made.*

*However, this does not preclude identifying from the facts where a decision or action/inaction constitutes a failure to satisfy the appropriate standard of performance. A reference to the "failure" to do something that should have been done is not a finding of civil liability.*

This investigation is not an inquiry under the *Public Inquiries Act*, but pursuant to ministerial order by the Minister of Justice under the *Police Act*.

Although the Ministerial Order makes reference to the Criminal Code—

*Whether the Truro Police Service complied with all appropriate training, policies, procedures, guidelines, Nova Scotia statutes and regulations, and the Criminal Code (Canada) in relation to the events of August 28, 2009 . . .*

—this investigation does not have the authority to examine events through a lens of potential criminality.

A legal opinion was obtained regarding the authority of this investigation to examine any issue under the lens of potential criminality. Ms. Jean McKenna advised:

*The Supreme Court of Canada in Starr v. Houlden, [1990] 1 SCR 1366, very clearly prohibits a provincial inquiry into criminal conduct . . . The Court held that the inquiry was a matter coming within the exclusive federal power over criminal procedure and was outside the competence of the Province.*

*It appears that the reference to the Criminal Code in the Ministerial Order, in my opinion, cannot include a requirement that you investigate any possible Criminal Code violations by the Truro Police Department; rather it would be with respect to issues regarding reasonable and probable grounds for the arrest, etc. . . .*

It is important for the reader, Victoria Rose Paul's family, and the Mi'kmaq community to understand that this investigation has no authority to conduct a criminal investigation into this matter.

This investigation provides an independent examination of the interactions of TPS and particular staff members involved with Victoria during the time of her arrest, detention, and release to the hospital. It also reviews and critiques the subsequent investigation conducted by HRP into the matter. Through a thorough examination of the facts, interviews, meetings, research, and policy and standard reviews, this team has conducted an investigation in keeping with the principles of natural justice and provided me with diverse perspectives from varying skill sets.

We have identified the following legislation, regulations, and policies as applicable to the terms of reference set out by the Minister:

The Nova Scotia *Police Act* and regulations

*Liquor Control Act*

*Court Houses and Lockup Houses Act*

Truro Police Service policies

Provincial lock-up standards

The relevant provisions are set out in Appendix D.

## Part 1: The Arrest

Section 87 of the *Liquor Control Act* prohibits intoxication in a public place and allows officers discretion to charge an individual or place that person in an appropriate treatment or care facility. Currently, Nova Scotia has very few such places to hold persons who are intoxicated, therefore making it necessary for them to be detained in municipal lock-up facilities until they reach a point of sobriety in which they are unlikely to be a safety concern to themselves or the public.

At approximately 3:00 am of August 28, 2009, Cst. Monica Garland (formerly of TPS) noted the bouncers from the Warehouse Bar, in Truro, NS, had removed a male patron from the establishment. Cst. Garland advised units in the area of the situation and that she was going to stay to ensure there were no problems. When Cst. Garland exited her vehicle, a female patron was removed by staff from the establishment. Victoria Rose Paul and her son, Deveron Paul, were later identified as being the patrons removed from the Warehouse Bar.

Cst. Garland approached the Pauls, and Victoria identified herself as Deveron's mother and that she was going to take him home. Staff from the bar advised the officer they thought Deveron was on conditions and that he had something concealed in his pants. Cst. Garland tried to assess the situation, but Victoria became upset and insisted she would take Deveron home. At this time, Cst. Garland noted there was something concealed in Deveron's pants, but she could not ascertain what the item was.

Constables Kevin D'Entremont, Geoff Green (both formerly of TPS), and Rob Hunka arrived on the scene. Cst. D'Entremont advised Victoria not to intervene, so officers could do their job, and tried to keep Victoria away from Deveron so Cst. Garland could speak with him. Victoria became more agitated and pushed Cst. D'Entremont out of the way in order to get to her son. Constables D'Entremont, Green, and Garland tried to restrain Victoria in order to handcuff her. Victoria continued to resist arrest and was taken to the ground to be handcuffed. Cst. D'Entremont arrested Victoria pursuant to Section 87(1) of the *Liquor Control Act*.

While officers were handcuffing and arresting Victoria, Deveron became upset and started reaching for the waistband of his pants and became verbally aggressive with the bouncers. Cst. Hunka believed the situation was escalating and was concerned for officer and public safety. Cst. Hunka proceeded to place Deveron under arrest but required multiple bouncers to assist him in restraining Deveron in order to place handcuffs on him. Deveron was arrested pursuant to Section 87(1) of the *Liquor Control Act*. (Appendix E—Supplementary Occurrence Reports). These officers advised they had no prior knowledge or involvement with either of the Pauls.

Cst. Garland transported Victoria to the TPS lock-up facility, while Deveron was transported by Constables Hunka and Green to the facility.

We were provided copies of the videos from the Warehouse Bar showing a washroom facility where an alleged incident took place that prompted the removal of the Pauls from the bar. Video footage showing staff removing the Pauls from the establishment was reviewed. Video footage from the Inglis Place camera was viewed showing the arrest and placement of the Pauls in police vehicles.

Audio statements were gathered by my team from Cst. Hunka, Mr. D'Entremont, and Ms. Veinotte (formerly Garland). Mr. Green provided a written statement, as he was out of the province. Officers described Victoria's condition at time of arrest as

*... overpowering odour of alcoholic beverages emanating directly from her breath ... She was to the point where very strong odor, her speech was slurred ... her eyes were glossy, she ... unsteady on her feet. She showed signs of impairment by way of alcohol. She had a kind of slur to her speech, she was quite unsteady with her feet, and very aggressive towards police officers.*

Review of the C13-4 form for Victoria at the time of booking described her breath smelling of alcohol, her speech slurred, her balance as wobbling, and her consciousness as alert. The log sheet for cell checks regarding Deveron noted at 12:38 pm that he advised the custodian that his mother "consumed over 12 beer and 1 quart of rum—minimum."

Further evidence, which will be examined later from the medical examiner, will show that he concluded that Victoria's stroke was not the result of trauma.

## **Part 2: Transportation to Cells and Booking**

As mentioned previously, Victoria was transported to the TPS lock-up facility by Cst. Garland, a female officer. Deveron was transported to the TPS lock-up facility by Constables Hunka and Green. Both police vehicles arrived at the lock-up facility, and Victoria went through the booking process first. While Victoria was being booked, Deveron remained in the police vehicle with Cst. Green in the sally port (facility entrance) area. We were told the video for the sally port was not saved, as the camera is not located in a position that shows persons in custody being removed from the car; therefore, we were not able to examine the time Victoria was removed from the vehicle or the time Deveron was being held in the police vehicle.

There are both provincial standards and Truro Police Service Standard Operating Procedures (SOP) that apply to the booking and detention of Victoria Rose Paul. I will break down the particular provincial standards and policies of TPS as they relate to the events.

## ***a) Prisoner Search and Required Booking Form***

### **Provincial Standard (1992)**

*39.5.1 A written directive requires that a search be made of all prisoners before entry into the detention facility and that a written, itemized inventory be made of all property taken from a prisoner.*

*39.5.3. A booking form is completed for every person booked into the facility and contains the following information: arrest information, apparent physical condition, and property inventory and disposition.*

### **Truro Police Service Standard Operating Procedures (2007)**

*D.4. The arresting member will conduct a personal search of all persons arrested to remove any item that could be used by the prisoner to cause harm to themselves, as well as to secure and protect personal property. If a prisoner is a female, the search shall be conducted by female custodian or female police officer.*

The booking area video showed Victoria was brought into the booking area at 3:08 am. Constables Garland, Hunka, and D'Entremont were present, as well as Mr. Gordie Clyde, the custodian on shift. The video for the booking area has audio in addition to the visual recording. Victoria could be heard in the sally port area prior to coming into the booking area. Victoria's tone was loud, and she was swearing at the officers. She asked where her purse was, and one of the officers advised her it was still in the police vehicle.

Cst. Garland started the search process of Victoria's person in the booking area. Victoria was still in handcuffs and she could not remove her boots on her own. Victoria was escorted to cell 7 to continue with the search and the removal of her boots and jacket. Corporal Kelly Moore-Reid (female officer now with the New Glasgow Police Service) took over the search process for Cst. Garland because Victoria was uncooperative with this female officer. Cpl. Moore-Reid was the on-duty NCO (non-commissioned officer) at this time.

Once Victoria was in the cell, Cst. Garland filled out the prisoner form referred as the C13-4 (Appendix F). This form is completed in order to capture the required information as contemplated in the provincial standard. Usually the arresting officer completes the C13-4, which documents arrest information and the state of the prisoner, lists possible concerns, and provides an inventory of the prisoner's personal effects that are removed and secured until the person is released. In this case Cst. D'Entremont did not fill out the C13-4; Cst. Garland did.



### ***b) Completing of Required Booking Form (C13-4)***

TPS uses the C13-4 form to gather the required prisoner information at time of booking. Cst. Garland filled out the C13-4 after Victoria was placed in cells. Cst. Garland acknowledged in her statement that Victoria Rose Paul was not known to her and this was her first interaction with her.

Cst. Garland checked on the form that Victoria had liquor on her breath, balance as wobbling, state of mind as angry, speech slurred, and consciousness as alert. Cst. Garland made no notation in the boxes on the form with respect to checking Victoria's rousability, if she was fit to be incarcerated, any illness, possible cause of intoxication, any injuries, or if any medications were required.

Review of the C13-4 for Deveron Paul, while completed by another officer, showed similar deficiencies. During our interviews with officers, on-duty NCOs, and custodians, it became clear that there was no consistent practice of filling out this form; therefore, information that may be of importance was not being asked for or documented. This information is important for the custodians to be able to refer to when watching prisoners, and for the next shift custodian or on-duty NCO to have access to when assessing a person in custody.

### ***c) Assessing if Prisoner is Fit to be Incarcerated at Time of Arrest/Booking***

#### **Truro Police Service Standard Operating Procedures (2007)**

*D.8. The health of the prisoner, including any injury, or medical alert bracelets shall be determined prior to him/her being placed in the cells. Should any serious injury, illness (epileptic, heart condition) be known, or the prisoner require any medication, the arresting officer shall ensure the NCO on duty is immediately notified and the person taken by ambulance to be examined at Colchester Regional Hospital before admission to Lockup. Should the on duty NCO feel there is no immediate threat to the prisoner's life, transport can be provided by police, but only in non-emergency situations.*

*D.11. Individuals who are brought into custody in a state of apparent sleep or unconsciousness must be woke prior to being placed in a cell. The 4 R's of rousability model should be used as a guide when attempting to assess a prisoner's level of rousability (See Appendix F). If the arresting officer is unable to wake the individual, he/she will be immediately transported to hospital by ambulance to be examined by a physician.*

*D.12. The on duty NCO will be advised of the individuals in a state of apparent intoxication who have a known history of drug overdose, a medical history that may be associated with an altered level of consciousness (diabetes), or a history of significant head trauma. These individuals shall be examined by a physician prior to being held in Lockup.*

These policies are to facilitate the arresting officer's assessment of the person in custody in order to determine that he or she is fit to be incarcerated. Police officers are not medical professionals but are tasked with the responsibility to ensure the safety and care of the individuals in their custody. As such, officers have to complete some form of assessment of individuals prior to placing them in cells.

This can prove to be a difficult task when dealing with individuals who may be intoxicated, have consumed drugs (prescription or illegal), have mental health challenges or other medical conditions, or any combination of these factors. In the matter of Victoria Rose Paul, there is little question that she was under the influence of at least alcohol at the time of her arrest. However, there is no documentation to support that she was asked any questions to assess her health, state of intoxication, what she may have consumed, or if she had any injuries or required medication.

The officers at the scene had reasonable and probable grounds to believe Victoria Rose Paul was under the influence of alcohol at the time of her arrest. TPS policy states that the arresting officer must determine the health of the prisoner prior to placing him or her in cells. The C13-4 and a tool referenced in TPS' policy known as the 4 R's of Rousability (Appendix G), help officers assess the condition of the prisoner by requiring certain questions to be explored with the person in custody regarding his or her health, medical requirements, medications, etc.

When interviewed, Cst. D'Entremont advised he did not ask Victoria any questions to assess her health or how much she may have drank. He indicated that these questions would be answered on the C13-4, but he did not fill out the form for Victoria. Ms. Veinotte (formerly Cst. Garland) did not have any concrete recollection of the events on August 28, 2009, when interviewed. She did not recall asking Victoria any questions, but she did fill out the C13-4. The other officers at the scene or booking did not recall asking Victoria any questions regarding her condition.

During the prisoner search when Victoria's boots were removed, Cpl. Moore-Reid discovered Victoria's left leg was wrapped, and Victoria indicated that her leg/ankle was sore. Cpl. Moore-Reid stated that this was the only injury Victoria mentioned and does not recall any discussions about any other health issues. She did not recall asking Victoria anything further. Cpl. Moore-Reid was of the opinion the leg was professionally wrapped by a doctor and made the decision to leave it on Victoria's person.

Cst. Garland described Victoria as alert on the C13-4. The video footage showed Victoria walking on her own accord, communicating with the officers, and responding to their requests. Once in her cell, Victoria was able to sit down, bend over and take the bandage wrap off her leg and re-wrap it in a manner that it ended

up staying on the entire time she was in cells. She then put her sock back on and fixed her pant leg—all unassisted and without falling or fumbling.

Victoria's physician advised my investigative team that Victoria was being treated for chronic anxiety and chronic pain since 2000 and received prescriptions approximately every month. Victoria was prescribed LECTOPAM (6 mg four times a day), an anti-anxiety drug that is noted to be habit forming and the consumption of alcohol is to be avoided. Possible side effects noted are that it affects coordination and mood, and may cause drowsiness. She was also prescribed ENDOCET (10 mg three times a day), a controlled narcotic painkiller containing oxycodone, in which the consumption of alcohol may intensify the effects of the drug. Possible side effects noted are agitation, dizziness, and nausea. This drug is also noted to be potentially habit forming. Victoria received her last prescriptions for these drugs on August 11, 2009. The toxicology report from the hospital confirmed traces of cannabis and benzodiazepines (anti-anxiety medication) in Victoria's system.

Officers and NCOs in charge of shifts involved in the incident of August 28, 2009, stated in their interviews that there is no consistent approach to assessing persons in custody to determine if they are fit to be incarcerated. Cpl. Moore-Reid stated that it came down to officer opinion; there was no standard or risk assessment to determine a prisoner's fitness to be incarcerated. Sgt. Lee Henderson, the second on-duty NCO for the time Victoria was in police custody, advised investigators in his statement that it was not common for officers to ask people if they were on medications, or what they may have consumed. Other officers advised it was a "judgement call" with respect to determining if prisoners were fit to be incarcerated and relied on individual prisoners self-disclosing if they had medical issues or required medication.

A review of other police agencies' policies in the province reveals a number of policies that highlight the importance of proper documentation and assessment of the prisoner prior to placing him or her in cells, and the importance of advising the next person on shift of the information. These policies also make it clear whose responsibility it is to complete such forms.

TPS policies provide a tool commonly known as the 4 R's of Rousability for arresting officers to assess the physical state of a person in custody prior to placing him or her in cells. The 4R's originates from the Metropolitan Police Service (London, England) policy and has been adapted in RCMP policy. This tool assesses the following four points:

- Rousability: Can the prisoner be woken?
- Response: Can the prisoner answer simple questions such as his/her name, where he/she lives, or where are you?

- Response to Commands: Can the prisoner open his/her eyes on command, lift arm, etc.?
- Remember: Keep in mind the possibility of other illnesses/medical conditions such as diabetes, stroke, overdose, head injury, or epilepsy.

The guide also states: When in doubt call an ambulance.

At the time of booking and placing in cells, Victoria was described as alert and was able to answer questions and follow commands.

Of the nine (9) TPS officers interviewed, six (6) admitted they were not aware of the 4 R's of Rousability that is in their policy. One of these individuals was an on-duty NCO during the incident of August 28, 2009.

Another common term used in the policing community is "questionable consciousness," which means a state of reduced awareness in which a person is not readily responsive. This term was not known to the TPS officers interviewed.

From my perspective and understanding of the appropriate provincial standards and TPS policies, it is not only reasonable but expected that officers should try to gather at least the following information prior to placing a person in cells:

- Whether the person suffers from any injury or illness, either known or suspected.
- Whether the injury or illness was before or during the arrest.
- Whether the person suffers from any allergies.
- Whether the person is taking any medications.
- Whether the person received treatment from ambulance personnel at the scene or refused such treatment.
- The contents of any medical information bracelet.
- Whether the person consumed any alcohol, prescription drugs or illegal drugs, and how much and when.

I recognize that officers may not get this information, but it shows due diligence on their part to thoroughly assess the person to help them determine if he/she is fit to be incarcerated. If the information cannot be obtained from the person in custody, officers should document this on the prisoner information form. It is essential for officers and custodians to remember that common symptoms from alcohol intoxication are similar to other medical conditions such as alcohol poisoning, head trauma, diabetes, drug overdose, or other neurological disorders.

From the evidence provided and reviewed, it appears there was no assessment of Victoria's condition beyond the fact that she had consumed an amount of alcohol to

make her intoxicated. There is no evidence to support whether Victoria was asked what or how much she consumed, if she was on any medications, or had any injuries or medical conditions.

We now know that Victoria had more than alcohol in her system the night she was arrested. This stresses the importance that has to be placed on the initial assessment of individuals before placing them in cells. Again, I recognize that officers may not get the information they require from the person in custody, but it shows that attempts were made to gather as much information as possible in order to make an informed decision to place the person in lock-up.

TPS has a policy that individuals known to the police in a state of apparent intoxication with a known history of drug overdose or a medical condition that may alter their level of consciousness shall be assessed by a physician prior to being placed in cells. This level of precaution is both prudent and reasonable. But there are many persons in custody that come into the lock-up facility that are not known to the TPS, and this facility is often used to hold prisoners from other agencies, such as the RCMP. It is of paramount importance that individuals are assessed to ensure they are fit to be incarcerated. TPS has shown they do not have a consistent approach in dealing with this matter. Ongoing assessments of persons in custody will be discussed later.

### **Part 3: Care and Monitoring of Victoria Rose Paul while in Truro Police Service Custody**

#### ***a) Required Prisoner Checks***

##### **Provincial Standard (1992)**

*39.5.6. A written directive prescribes methods for handling, detaining, and segregating persons under the influence of alcohol or other drugs or who are violent or self-destructive.*

*39.8.2 A written directive requires that each prisoner be visually observed by department staff at least every 30 minutes.*

##### **Truro Police Service Standard Operating Procedures (2007)**

*1.6. When the prisoner is detained for intoxication, the custodian shall wake the prisoner every 30 minutes. If the prisoner is unable to be woken, the NCO shall be immediately notified, and an ambulance requested.*

*D.13. An individual who is detained in Lockup for intoxication shall be woken every 30 minutes and assessed for alertness.*

*I.4. The on duty custodian shall physically check each prisoner at least every fifteen minutes, or more frequent should conditions such as mental stability, or intoxication dictate. The times of these checks, and actions of prisoner shall be recorded on Log sheet.*

*I.5. The on duty custodian shall observe the monitors located at the booking counter during the time between physical checks of prisoners, and record any pertinent observations on Log Sheet.*

The province recognizes in its provincial standards that detention facilities, such as municipal lock-ups, are not the ideal place for persons who are under the influence of drugs or alcohol. The following comment can be found with Provincial Standard 39.5.6:

*Comments: The detention facility is not normally equipped to provide treatment to persons under the influence of drugs or alcohol, and such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensuring that the potential for prisoners to injure themselves or others is minimized. Such prisoners should remain under close observation by facility staff.*

Several officers interviewed during this investigation raised this as a concern. In his statement, Chief MacNeil (TPS) stated:

*The lock-up is the biggest risk any agency runs, and gets more so all the time. There's people with mental health issues, people with addiction issues, there's people with all kinds of medical history that you don't know about, and they're mixed with a cocktail of liquor, of alcohol, of non-prescription drugs, prescription drugs, you name it . . . And we do our best and we do a very good job at it of keeping people safe the best we can, and if they're in need of help, we get help for them . . . I'm a big believer of some of the way they have it out west that they have detox centres for people who are intoxicated. They probably shouldn't be in my lock-up, they shouldn't be in Halifax's lock-up, they shouldn't be in Cape Breton's, they shouldn't be in RCMP detachment. We're not set up for that. But we're it, unfortunately, right.*

In his statement, Deputy Chief McNeil (HRP) stated:

*. . . nobody wants drunks . . . Nobody wants them. The province dumped them years ago, and they don't want them back . . . [Lock-up facilities] it's the only place for them to be . . . But when you have a drunk in your cells, it's equivalent of a child. You have their control, you take over their liberty, they're vulnerable, they're all those things. So it's not like an adult who's making a decision to do X, not to do that, because you've taken all those decisions away from them. But people don't always understand that.*

Nova Scotia currently has very few wet shelters, or better-suited places to detain such individuals. With no other alternative, police are faced with the care and custody of such individuals until such a time as they are no longer a danger to themselves or the public.

The lock-up facility at Truro Police Service has the capacity to hold 14 prisoners within its seven (7) holding cells. Cell 5 has an authorized maximum capacity of eight (8) prisoners; the remaining are single cells. Truro's facility is able to detain males, females, and youth in the required segregated form outlined in the provincial standard. Victoria was placed in a cell away from the male prisoners that were detained on August 28, 2009, in keeping with the provincial standard. Of note, during Victoria's detention at TPS, there were four (4) other prisoners being detained. The other prisoners were male, one (1) of these four (4) under the custody of the RCMP.

Truro's facility has cameras for each cell area as well as motion-sensor cameras in the hallways between the cells and the booking area and the sally port. The booking area has a camera that records audio in addition to visual. There are also monitors to view the cameras at the booking station (where the custodians are seated when not doing prisoner checks), at the on-duty NCO's desk, and in the dispatch area.

Mr. Gordie Clyde was the custodian on duty at the beginning of Victoria's detention. At 3:30 am, Mr. Clyde did his first physical check of Victoria. On the individual prisoner log form (Appendix H—log), however, he notes that he missed this check due to "processing prisoner." Mr. Clyde completed 14 physical checks on Victoria between the times of 3:30 am and 6:37 am. The majority of the checks conducted by Mr. Clyde lasted 4–6 seconds. The majority of the log entries by Mr. Clyde documented Victoria as lying on either her left or her right side and seen breathing. When asked what a prisoner check consisted of, Mr. Clyde informed us:

*We have to check on them and as long as you see that they're breathing fine . . . or they're moving, then everything is all right. But then after so many checks if, like . . . not just during the checks but also we're monitoring them on camera the whole time. But if we don't see if they're . . . breathing but you don't see any movement after, say, an hour or more, then we go in and we physically speak to them. If they answer then everything is fine. If they don't answer then we call upstairs and an officer will come down, we will open the cell, and the officer will go in and check everything out.*

When asked if he physically woke Victoria according to policy, Mr. Clyde stated he did not.

Mr. Clyde described his role as a custodian: "I was just there. I controlled the key basically. I was the one to unlock and lock the cells." Mr. Clyde believed his job was to ensure prisoners were still breathing and alive. He stated he did not wake Victoria,



as he could see her abdomen move while she was sleeping. During his 6:36 am cell check, Mr. Clyke found Victoria on the floor crying. He asked her if she was all right, and he stated Victoria told him “no” but that she did answer him.

Mr. Clyke did not report the matter to the on-duty NCO but did mention to the custodian who was taking the next shift that Victoria was on the floor.

Mr. Jim Skinner relieved Mr. Clyke and took over the next shift. At 6:44 am, Mr. Skinner did his first physical check on Victoria. Mr. Skinner completed 27 physical checks on Victoria between 6:44 am and 12:52 pm. Mr. Skinner’s checks lasted between 3 seconds and 2 minutes and 15 seconds. The majority of the log entries by Mr. Skinner documented Victoria as lying on the floor, crying or groaning.

Video footage at 6:44 am showed that Victoria was on the floor and her pants and undergarments had come down, exposing her. During his interview, Mr. Skinner advised he asked Victoria if she was all right, and she responded “no.” This interaction was not noted on the log and the time is not clear.

Mr. Skinner continued with his required checks, as per policy, throughout his shift. At 8:00 am he noted in the log that Victoria was “Laying on floor. Moving and Yelling”; at 8:10 am he noted on the log that Victoria was “Unable to be coherent”; and at 8:13 am he noted on the log “Called Duty Sgt.”

At 8:16 am, Mr. Skinner, Sgt. Henderson, who was the on-duty NCO for this time, and Cst. Rick Hickox arrive at cell 7. Sgt. Henderson requested that Cst. Kelly Manuel (now Quinn, a female officer) return to the station and assist with Victoria. This interaction will be examined in more detail in the next section looking at assessments of Victoria.

Mr. Skinner advised us in his statement that he was directed to do more frequent checks on Victoria by Sgt. Henderson and noted it on the log. In his statement, Sgt. Henderson stated he did not direct more checks but that Mr. Skinner suggested this action. Neither the log nor the video confirm that five (5) minute physical checks were completed. The log does not further indicate visual checks by monitor were more frequent. Sgt. Henderson further advised that he provided no direction to staff regarding Victoria.

At 8:45 am, Mr. Skinner noted in the log: “Woke prisoner to get a verbal response. Prisoner less vocal. Has pissed her pants.” The log shows Mr. Skinner continued with his physical checks, documenting a decrease in response from Victoria to his checks to rouse her. The log reflects Mr. Skinner only got slight movements from Victoria and her only verbal response was a groan. Mr. Skinner did not advise Sgt. Henderson that Victoria had urinated in her pants or that she was lying in urine.



Mr. Gerard White was a senior commissioner from Nova Scotia Commissioners at this time. He currently is a civilian employee with TPS as a dispatcher. He was assigned as supervisor of the other commissioners on site but was not responsible for overseeing their duties when in lock-up. This was the responsibility of the on-duty NCO. Any difficulties custodians may have encountered on shift were to be directed to the on-duty NCO, not Mr. White.

Sometime between 11:00 am and 11:30 am, Mr. White was escorting someone from network services through the booking area when Mr. Skinner advised him there was an issue with a female prisoner:

*Commissionaire Jim Skinner, was the guard . . . he came out of the booking area and he said could I see you for a minute? And I said certainly. So I just . . . I stepped out just in the hallway, and he said to me, he said, look . . . I can't remember the exact words, but it was something to the effect I've got some concerns about the lady we have in the lock-up. And I said to him, did you inform the Duty NCO, who was Sgt. Henderson, and he said yes, I did. I said, well, what did he say? And he said, well, he told me that my job here was to ensure that she was alive, and that if I had any concerns I could check her more often, so he said I'm checking her every five minutes. And I said, okay. But he said, when I check her, he said, I go in and he said all she's does is she just grunts at me. And I . . . I looked at him, and I said so as long as she's grunting at you she's still alive. I said that assuming that what he was telling me was telling . . . he told Sgt. Henderson . . . I think I told him right then, when I go upstairs, I said, Sgt. Henderson was sitting at the desk when I came down, I'll ask him to come down and check on her. And he said, okay.*

The video and log confirm that Sgt. Henderson went to Victoria's cell at 12:25 pm. He stayed for approximately 25 seconds and then left the facility and went on the road. Video shows Victoria lying on her stomach saturated in urine. When asked about this check, Sgt. Henderson stated: "No, I don't even recall going down, so . . . I don't even know why . . . why I would've went down".

When asked what a prisoner check consisted of, Mr. Skinner informed us:

*Usually all you had to do was speak and they'd answer you. And sometimes you had to speak loudly, because if they were asleep, you'd rouse them. She's probably the only . . . prisoner I ever had that I was, unless they were up and standing at the bars, able to reach out and touch, and that's because of where she was on the floor. And so it was only verbal. Everything was . . . prisoner before that was always a verbal response . . . And with her that didn't work. Other than the very first thing I said, are you all right, and she said no.*

Sgt. Henderson advised that custodians were to rouse or check on prisoners in the following manner:

*They look to see if they're breathing, . . . they'll call their name out, and you know, if they feel that they're not . . . getting the response that they should, then they'll call an officer and either the NCO or the NCO will send an officer down to go into the cells and . . . shake them and rouse them.*

Cpl. Moore-Reid provided the following in her statement:

*[Commissionaires] They weren't really advised how to do, they just know they had to. So if they're going in and they did yell, tap the bars if you weren't getting . . . like someone snoring hard, and there'd be some, they really were . . . sleeping. I mean you may have to bang on the bars or bang on the first door because that would make more of a racket, same as when you're banging on a house door so you wake people up. Some would just give a bellow, someone might whistle. It'd be a way to wake them up to make sure they're . . . like I said, you had to make sure they're breathing, so you're going to . . . it was very rare that you ever had to go in and give them a little rub to the sternum, like that would be rare.*

Truro's policies regarding prisoner checks exceed the provincial standard. Truro requires its custodians to do a physical check on prisoners every 15 minutes, to rouse or wake them every 30 minutes, in addition to visual checks on the monitors. All physical checks are to be noted on individual logs, and anything of consequence to be recorded from the visual checks from the monitors.

The provincial standard 39.8.2 only requires that persons in custody be checked visually every 30 minutes. I believe 30 minutes is too long before checks are made on persons in custody, in particular individuals who may be intoxicated or have some medical concerns. Also, the standard is not clear on what visual means: is this by monitor alone or an actual physical check? This standard needs to be updated and clarified.

In the matter before us, routine physical checks were completed on Victoria Rose Paul and noted on the log form. There were a few instances where the log did not correspond with the video footage. Review of the cell videos did show that the majority of the cell checks consisted of opening the door to the cell area (keeping hand on door), a brief look at the prisoner, and then closing the door.

The matter of Mr. Clyde not waking Victoria as per policy will be examined in the next section. Both Mr. Clyde and Mr. Skinner are no longer with TPS, and it is my understanding that their reasons for leaving were unrelated to this matter.

## ***b) Determining Victoria Rose Paul's Alertness***

### **Provincial Standard (1992)**

*39.6.1 A written directive identifies the policies and procedures to be followed when a prisoner is in need of medical assistance.*

### **Truro Police Service Standard Operating Procedures (2007)**

*D.10. At any time during incarceration, should a prisoner complain of a medical problem or the need for medication, the on duty NCO shall be notified and the prisoner be taken by ambulance to Colchester Regional Hospital for examination.*

*I.7. Should a prisoner complain of any illness, injury, or a suicide attempt be made, the on duty NCO shall be notified immediately and medical aid provided as soon as possible.*

*C.4. Personnel employed in the Lockup Facility shall report any incident involving injury, property damage, illness, or failure of equipment under their control to the on duty NCO. The supervising NCO shall report any major incident to the Chief of Police or D/C of Police.*

*D.14. The on duty NCO will be advised if at any time a prisoner is not able to be woken, or is unconscious. The prisoner shall be immediately taken by ambulance to Colchester Regional Hospital.*

*L.7. In the case of intoxicated persons, the on duty NCO shall release as soon as practicable, considering state of persons intoxication.*

Provincial standards and TPS policies set out a requirement for officers to conduct an assessment of a prisoner prior to placing the prisoner in cells to ensure that they are reasonably certain the individual is fit to be incarcerated. Once the prisoner is placed in the care of the custodian, the custodian is required to do the physical and visual checks and to physically rouse the prisoner as per policy. These checks are to ensure that the person in custody is still fit to be incarcerated and that his or her care and safety have not been compromised.

The policies do not define or advise how custodians are to wake or assess the alertness of persons in custody. And, as mentioned previously, the 4 R's of Rousability are not referenced as a direct tool for custodians in policy. TPS does not provide custodians clear parameters of what physical checks and checks to rouse prisoners should entail. The policies state that if the prisoner cannot be woken or is unconscious, the custodian is to contact the on-duty NCO and medical assistance is to be provided.

Interestingly, when asked about the 4 R's of Rousability and determining if a prisoner was fit to be incarcerated, Mr. Clyke recalled seeing the 4 R's in the policy binder and had a sense of what they meant. Mr. Skinner advised he was not familiar with this tool.

When Mr. Clyke found Victoria lying on the floor crying at 6:36 am and she responded "no" to his question if she was all right, he stated he did not probe her any further to find out what was wrong. He stated he thought she was only upset. He did advise the next custodian during shift change that she was on the floor.

When asked by this team how custodians become aware of the condition of prisoners coming in, or when taking over a shift, Mr. Clyke advised: "They [booking/arresting officers] usually don't inform us of everything like that, but most of it is on the C-13, and we can usually find that information there." Mr. Skinner advised: "We never . . . never received direction when somebody was brought in."

Victoria's manner and behaviour were markedly different at 6:17 am than during the previous three (3) hours. Mr. Clyke believed Victoria was still intoxicated, and he never considered any other reason for this changed behaviour, nor considered how different her behaviour was at this time compared to the last three (3) hours he had been responsible to watch and check her. Mr. Clyke did not follow policy with respect to waking Victoria every 30 minutes; nor did he report the change in behaviour and her response that she was not well to the on-duty NCO.

Cpl. Moore- Reid was the on-duty NCO who put Victoria in cell 7. She stated:

*I don't recall any medical concerns with her other than the ankle . . . I mean this poor lady, if she had a stroke in my presence, . . . I did not see it, but I don't yet . . . I've yet to figure out what I should've looked for.*

At 8:10 am, Mr. Skinner noted in the log that Victoria was not coherent and he made a call to Sgt. Henderson, the on-duty NCO. At 8:16 am, Sgt. Henderson and Cst. Hickox went to Victoria's cell. Sgt. Henderson called for a female officer to come to the cells to assist in pulling Victoria's undergarments and pants back up and to fasten them. Video footage shows at 8:20 am Constables Kelly Manuel and Greg Densmore arrived at the cell, and Cst. Manuel assisted with this request. Cst. Densmore did not assist with Victoria but stood by with Mr. Skinner. Sgt. Henderson and Cst. Hickox returned Victoria to the bunk, and then Sgt. Henderson made the decision to put Victoria back on the floor so she would not fall off the bunk again. Victoria was placed on her right side, however rolled onto her stomach 20 seconds later. It is noticeable from the video that Victoria had urinated herself.

Sgt. Henderson described in his statement his interaction with Victoria at this time:

*And I think she was laying on the floor at the time. I yelled at her, Victoria, Victoria, and sort got a mumble or groan, and we . . . I believe her pants might've been down part way or something, so I contacted Cst. Quinn . . . Manuel at the time . . . to come in and assist pulling her pants up. So she come in. We . . . we pulled her pants up. She was breathing, mumbling. I can't really say if there was anything legible there or not. I can't remember. We started to lay her down on the bench. I suggested looking at it and . . . that she was highly intoxicated, that maybe we better put her down on the floor and just lay her there and make her more comfortable there. I didn't want her to fall off and injure herself . . . [Mr. Skinner] he said that he would keep an eye on her and check her every five minutes. I said that's fine. I said if there's any problems, call me.*

Further in his statement, Sgt. Henderson advised when he went to check Victoria at 8:16 am he had some awareness that she had been placed in the cell in the early hours of the morning, but did not know that she had been there for over five (5) hours at this time.

Sgt. Henderson advised my investigative team that he concluded Victoria was still intoxicated at this time. When asked how he could explain the decline in her behaviour compared to the information that was documented on the C13-4, five (5) hours earlier, Sgt. Henderson stated he never reviewed the information available to him so he was not aware that there was a decline. Without availing himself of all the information available regarding Victoria, Sgt. Henderson concluded Victoria did not require any medical assistance at this time and left her on the cell floor. Victoria's behaviour at 8:16 am was in stark contrast to the time at booking, five (5) hours previous, when she was able to walk and stand unassisted, described as alert, and was able to communicate and be understood.

Sgt. Henderson advised that on-duty NCOs are now required to review the C13-4 of persons in custody when they start their shift. Sgt. Henderson stated that there is more information being filled out by officers on the C13-4 and they are placed on the sergeant's desk for review and for the next shift on-duty NCO to see. He believed this was one of the recommendations from HRP's investigation.

Sgt. Henderson was asked by this investigative team what type of responses did he deem satisfactory from a person in custody; he stated:

*. . . if they lift their head up, or . . . they say something, or they mumble, or . . . and they're breathing, you know . . . I would think that that's, you know, they're still alive and breathing, and . . . and maybe some sort of indication of speech."*

When asked to further explain how he felt these were adequate responses from Victoria, Sgt. Henderson advised:

*She . . . appeared to be highly intoxicated. She was breathing. Sat her up. Can't say whether she said anything legible or not, but she did mumble, and didn't appear anything more than her being intoxicated.*

*Unfortunately at that point in time, you know, there was no indication that I saw that would advise me of any other thing, and if there was, she would've had medical attention.*

The constables present at 8:20 am did not raise any concerns to Sgt. Henderson regarding Victoria's condition and believed she was still intoxicated. Constables Quinn and Hickox confirmed in their statements that Victoria could not stand unassisted at this time. They also confirmed that they did not try to communicate with her; nor did Victoria interact or speak with them.

After officers and Mr. Skinner left Victoria in her cell at 8:24 am, she rolled onto her stomach 20 seconds after she was placed on her side. Video footage shows at 8:25 am visible signs of urine on Victoria's pants. Officers were asked if they noticed urine on Victoria, or smelled anything while in the cell. All of them advised my investigative team "no" with the exception of Cst. Densmore. He stated he thought it smelled like Victoria soiled herself. He advised that he mentioned this to the other officers but they did not respond to his comment other than they gave him a weird look. Mr. Skinner noted on the log at 8:45 am that Victoria had urine on her pants.

Mr. Skinner continued to do the required checks and tried to rouse Victoria for the remainder of her time in the TPS lock-up facility. Mr. Skinner did not have a sense what was wrong with Victoria and had no information at his disposal to have a better understanding of what was going on with her, as the C13-4 gave him no information. He advised:

*But I could never get a response from her. Different times I went in to her son, Deveron, to ask, like how much did she have to drink? Does she have a health problem? Are there concerns I should have. And I knew it would, but I felt it was safer to have him upset than not to know, so I would keep questioning as the evening went on.*

Deveron Paul told this team he asked the custodian around 8:30 am about his mother and was told she was still asleep. Deveron stated he asked Mr. Skinner to wake her up and tell her he was being remanded to Central Nova Scotia Correctional Facility:

*And usually my mother gets up early, so . . . even when we do drink, so I said, yeah, it's like can you go over there and wake her up for me anyways? He said, uhhh, I'll try. And he goes over there. He says something about he . . . he shoved her foot with his pen.*

*He said, I pushed her on her feet with my pen. And he said all she did was moan. And then he came back and then he told me that . . . I said usually my mother would be up right now. I said you should check on her though because usually she gets up early all the time no matter how much we drink. . . I said there's something . . . there's something wrong with her. He asked . . . he said, is your mother on any medication? And they should already know that because when you get arrested there and you get thrown in the drunk tank they take everything out of your pockets. They go through all your stuff. But he's asking me if she's on any medication, and obviously she's got high blood pressure pills in there, and whatever else medication she takes. And I . . . that's what I told him, I said she takes some kind of pills. . . I knew my mother's cell was one of the cells that I was walking by, so I looked in them, and they were like, don't worry about it, your mother's not here anymore. I said where's my mother? Oh, we had to take her to the hospital, she wasn't feeling well.*

In his statement to this investigative team, Mr. Skinner made reference to striking a prisoner on the ankle with the metal detector. In his statement he stated he was shown by the on-duty NCO to do this to rouse Victoria. Video footage did not confirm at any time that Victoria was struck with a metal detector, but did show Mr. Skinner trying to make some contact with her feet, as they were close to the bars. The item in his hand looked to either be a key or pen. When asked to clarify his statement and who showed him how to strike persons in custody in order to rouse them, he advised it was a different on-duty NCO than the one that was in charge on August 28, 2009. This was brought to Chief MacNeil's attention.

Mr. Skinner continued to be concerned with the condition of Victoria:

*And my concern grew the longer, and then I got more insistent with the Sergeants, was that any time I'd had an impaired person in, after they'd been off alcohol for a certain period of time, they get a little more aware of who they are and where they are and what they're saying. She didn't. She got worse. And so I would keep a closer watch. I argued at different times with both Sergeants that we should call the health people. No, she was just drunk. And when my Warrant came in on duty in the morning, I spoke to him. Well, his first reaction to me was whatever the Sergeant had said, that's what I do. Okay. That's what the standing orders are, that's what you do. But, Gerard, this isn't normal. And he [Mr. White] come down, he did look. He did try to have a conversation with her. . . And shortly thereafter he allowed . . . some [one] authorised them to offer medical. . . From my perspective I feel I couldn't convince either of the Sergeants that night. I don't know why, but I couldn't, and that's why it bothers me because what should I have done.*

Mr. Skinner was asked when he felt Victoria required medical assistance on August 28, 2009: "Probably when Sgt. Henderson and the constable were there and they tried to put her back in the bunk. That'd would be at 8:17. Maybe before that."



Mr. Skinner advised the response he received from Sgt. Henderson was, "The grunt was that she's awake, or waking, so she's conscious. You've done your duty, you've got her awake."

In her statement, Cpl. Moore-Reid commented:

*... there's so much stress on them [custodians] to say make sure they're [prisoners] are breathing ... That ... you know, and you think, you know, everyone's breathing at the end of your shift. You're ... everything's good, you know, and you'll hear that. They're all good, they're all breathing, but you know, when you look at Ms. Paul in this case ... just because she was breathing didn't mean she was okay.*

TPS policy states: "The on duty NCO will be advised if at any time a prisoner is not able to be woken, or is unconscious. The person shall be immediately taken by ambulance to Colchester Regional Hospital." Mr. Skinner's experience with intoxicated individuals made him have concerns that Victoria was not showing signs of becoming sober and he believed she should be responding better than the condition she was presenting. Mr. Skinner advised his NCO and Mr. White of his concerns. He was of the belief he was not allowed to determine if Victoria needed medical assistance or allowed to call 911. Mr. Skinner stated only the on-duty NCO could make these determinations:

*I could not go above it. If I had phoned an ambulance, I would've had to have used an outside line. That's not a problem. But the minute the ambulance showed up at the door and they had to be admitted, then I would've been fired. Immediately. ... No job's that important. Yeah. I didn't stick my neck out and I should've.*

In his statement, Chief MacNeil confirmed that there was some confusion regarding this policy and that custodians may have felt they did not have the authority to call EHS:

*Correct. Well, the policy wasn't clear. I wouldn't say they weren't able to call. The policy said that if someone in lock-up requires medical assistance you had to get the NCO on duty and advise them. Not to say that if someone dropped on the floor and turned purple that you couldn't call 911. You're never going to get chastised for calling, however when ... that was one of the recommendations HRP when they read the policy said you should be a little more clear on that. Because it does ... it could lead someone to believe that the first call is to the NCO.*

The new TPS policy reads: "Anytime a prisoner is not able to be woken or is found unconscious, the lock-up custodian shall immediately contact EHS. The on-duty NCO will be notified immediately after EHS has been contacted and will attend the lock-up."



In the previous section examining required checks, Sgt. Henderson advised he did not recall checking on Victoria at 12:25 pm. The video footage and log confirm that Sgt. Henderson went to Victoria's cell at that time. He stayed for approximately 25 seconds and then left the facility and went on the road. Video footage showed Victoria lying on her stomach saturated in urine at this time. Because Sgt. Henderson did not recall this check when asked, he was not able to provide reasons why he concluded, nine and a half (9.5) hours after booking, that Victoria's condition and behaviour was consistent with someone still showing extreme signs of being intoxicated.

Around 1:00 pm, Mr. Skinner continued to be concerned regarding Victoria's condition. He called upstairs and Mr. White answered the phone. In his interview, Mr. White stated the following:

*A: I come back an hour later and I'd just gotten in the dispatch and the phone rang, and I saw it was the cell block. So I picked it up. It was Skinner, and he said, yeah, he said, there's no change in the lady ... in the lady, right? And I said ... he might've said Victoria, but anyway I know who he was talking about ... and I said, well, did the Sgt. go down and check on her? And he said no. I got ... I got a little upset when he said no, because he told me he was, and then I did something I ... I don't know why I did it, but I said, okay, I'll go check on her. I got to tell you, it's not my job to go check on her right, 'cause the dispatch ... or the access to the cell block is limited when there's somebody in lock-up. Only people that are ... have a reason to be down there are supposed to be there. That's not part of my job is to go down and do it, but anyway I got ... I got a little annoyed because the Sgt. didn't go down when he told me he did, so I went down. I go down, I go to the cell block, and I ... I opened up the outer door. Ms. Paul was laying on the floor with her back to me, away from me, and I said ... I said her name. I said Victoria, can you hear me? And at the time when he said all she did was grunt at me, I took to mean like it just ... don't ... you know, don't bother me. I'm ... you know, that type of thing. But when I said that to her, and I ... I yelled her name, she did the same thing to me. It was just like ... like it wasn't a moan, it wasn't a groan. It was like a ... just kind of grunted at me. And so I said, listen, Victoria, can you sit up on the bunk because, you know, we gotta ... it's time to get out of here, right? You've been in here long enough, and I'm yelling this. And it seemed to me at the time thinking back that she tried to move. I ... I think she did, but I got the impression that she couldn't. That was my impression. So I immediately left there, I went right upstairs. I called Sgt. Henderson on the radio, and I told him, I said I was down in the cell block checking on the female we have in the lock-up, and I think I said, in my opinion we're not getting the response we should be getting for the length of time she's been down there. And then I said can I call EHS and I told them ... I asked them to come and check on her ...*

*After that I was the one that was tasked to make all the videos [for Halifax police investigation] . . . I noticed that . . . I believe it was twenty after twelve, Sgt. Henderson actually went down and checked on her. I saw it on the video. He . . . the guard told me he didn't go down, but I was looking on the video and he went down. Anyway, that's what I saw and that was . . . that was it, and nobody's ever talked to me from that day until right now about it.*

*Q: It bothered you that you saw that he went down at twenty after twelve?*

*A: Well, it did because . . . the guard said he didn't and then I saw that he did, and I thought, if he went down at twenty after twelve, I don't know what he saw or heard, but I know what I saw or heard caused problems for me, so I . . . I made the radio call.*

Mr. White immediately called Sgt. Henderson to inform him Victoria was not responding and required medical assistance. Sgt. Henderson approved the call to EHS.

The policies do not define or advise how custodians are to wake or assess the alertness of prisoners. And, as mentioned previously, the 4 R's of Rousability or other assessment guides are not offered as tools for custodians in policy. Truro Police Service does not provide clear parameters of what these checks and assessments should entail for the custodians. The old policy stated that if the person in custody cannot be woken or is unconscious, the custodian is to contact the on-duty NCO and medical assistance is to be provided. While it can be argued that Victoria was awake in some fashion and not unconscious because she was making illegible noise, I do not believe she demonstrated that her condition did not necessitate medical consideration.

While the new policy allows the custodian to make the call to EHS, it still uses the language "not able to be woken or found unconscious." I believe it would be prudent for TPS to change this language to consider questionable consciousness and the person's alertness and overall well-being. I would also encourage all municipal police agencies responsible for lock-up facilities to adopt similar language in their policies.

Sgt. Henderson indicated that he believed Victoria was still intoxicated and that he did not realize she was in medical distress. However, Sgt. Henderson did not demonstrate that he had considered any other alternative to this behaviour and never completed an assessment of her condition. He made no effort to inform himself of Victoria's condition when she was first brought into the station to establish a baseline. As the on-duty NCO, Sgt. Henderson had a duty to be informed of the conditions of all persons in custody in his care in order to be able to assess any potential problems. In my opinion, this belief that Victoria was only drunk indicates complacency toward individuals who present themselves in an intoxicated state. This type of attitude has the potential to compromise the due diligence that is required to ensure all persons in custody are safe while in Truro police custody.

It is not enough to place someone in cells to “sleep it off.” If Victoria was still showing extreme signs of intoxication almost 10 hours after she was arrested and detained, I would think that would prompt a reasonable person to consider something was wrong.

It is important to note that police officers and custodians are not medical experts. None of the officers or custodians were responsible to identify what was wrong with Victoria. They did have a duty to recognize that she was in distress and was exhibiting behaviour that was not consistent with her behaviour at the time of her arrest and detention.

### ***c) On-Duty NCO Responsibilities***

#### **Provincial Standard (1992)**

*39.1.2 A written directive designates one person as responsible for the operation of the detention facility.*

#### **Truro Police Service Standard Operating Procedures (2007)**

*K.1. The on duty NCO is responsible for the operation of the Truro Police Service Lockup during the course of their shift.*

*K.2. When prisoners are being held during the course of their shift, the on duty NCO shall ensure all staff comply with the policies outlined in the Standard Operational Manual.*

*K.3. The on duty NCO shall visit the cell block area at least once during the shift, and record visit on the Prisoners log sheet.*

The provincial standard and TPS policies are in keeping with Section 10 of the *Court Houses and Lockup Houses Act*.

TPS is in compliance with the provincial standard 39.1.2. On-duty NCOs are designated to be responsible for the facility’s operation, including management of its personnel and persons in custody. Both Cpl. Moore-Reid and Sgt. Henderson were in charge of the lock-up facility when Victoria was being held for public intoxication.

In 2009, TPS employed its custodians through an agreement with Commissionaires Nova Scotia. This arrangement still holds today. These custodians are considered contract employees who assume responsibility of persons in custody, which includes checking on them according to policy. Custodians are not allowed to go into the cell with a prisoner, but are required to call the on-duty NCO to advise of the situation, and then the on-duty NCO will deploy officers as he or she sees appropriate. I question this practice when there are situations that necessitate immediate action and access to the person in custody, such as a hanging or other medical emergency.

Officers search and process the prisoners through booking, complete the C13-4, and escort the prisoners to the cells. The on-duty NCO has the overall responsibility for the facility, custodians, officers, and persons in custody. Chief MacNeil confirmed this in his statement, "... in my mind the policy is clear, that the NCO in charge on duty is responsible for the lock-up."

On-duty NCOs are responsible to ensure that all officers, civilian employees, and contract employees are complying with the appropriate policies. Mr. Clyke advised that his practice was not to follow the policy with respect to rousing prisoners every 30 minutes, thereby not waking Victoria as required. Review of the log completed by this custodian and his statement confirm he never attempted to wake Victoria. He also did not inform the on-duty NCO that Victoria advised him she was not well.

Mr. Skinner did not report as per policy to the on-duty NCO every time he could not get an adequate response from Victoria. Neither did he bring it to Sgt. Henderson's attention when he first noticed Victoria had urinated in her pants and was lying in this contamination.

The previous section of this report examining C13-4 forms showed that on-duty NCOs were aware of the inconsistent practice of officers completing these forms. Officers did not adequately complete the C13-4 for either Victoria Rose Paul or her son, Deveron Paul, as per policy.

The previous section of this report examining assessments of prisoners showed that on-duty NCOs were aware of inconsistent practices and lack of thoroughness of officers in conducting such assessments. Officers did not conduct a thorough assessment of Victoria Rose Paul before placing her in cells as per policy.

Cpl. Moore-Reid was on duty the first part of Victoria's detention. She believed she ended her shift around 5:30 am as Sgt. Henderson came in early for his shift. When confronted with information that Mr. Clyke did not wake or rouse Victoria according to policy, Cpl. Moore-Reid offered the following: "I had no idea that he wasn't following that policy ... And that if I was his supervisor would've come on me". She advised that it was her duty as the on-duty NCO to ensure that her staff, both custodians and officers, were following and administering the policies correctly.

Sgt. Henderson described his responsibilities as on-duty NCO:

*Just make sure everything's running. If there's any problems down there, then the Commissionaire is to call the NCO, and the ... in regards to policy, so if somebody comes in and they're asking for a blanket they have to call the NCO and get permission from the NCO in regards to a blanket, or a mattress. Or if they have medication, if they need medication and they have it with them, they have to call the NCO to see what we're going to do in regards to that.*

When asked if he was responsible for persons in custody, Sgt. Henderson replied:

*A: I don't know if I assume responsibility for that person, but I mean . . . the NCO is responsible for the cell area and what goes on down there. So as for being responsible, I'm not sure, you know.*

*Q: Hm..mm. Responsible for their care and safety?*

*A: I . . . I would say, yeah, we're probably, yeah. Make sure that everybody's treated equal and everybody has the same opportunities, yeah.*

Sgt. Henderson did acknowledge that if he was aware of a custodian doing something contrary to policy or incorrectly, he would have a responsibility as on-duty NCO to address it with the custodian.

It is reasonable that when a breach in policy by subordinate staff occurs, the on-duty NCO may not be aware of it at the time. Inconsistent practices with completing standard forms and assessing persons in custody were known by all staff interviewed, including the two (2) supervisors.

Sgt. Henderson directed Cst. Hickox to take the summary offense ticket (SOT) for being intoxicated in a public place with him to the hospital to leave with Victoria. Cst. Hickox advised that he checked the ticket as being personally served, when in fact he only placed it in her purse:

*[The SOT] it was put in her effects. I didn't actually physically give it to her. . . . I actually brought the summary offence ticket up with her effects at the request of Sgt. Henderson.*

Victoria was non-responsive at this time and could not be personally served. When asked about this, Sgt. Henderson stated he saw no problem:

*A: I think Cst. Hickox . . . just advised him to follow her out, and just leave the ticket out there with her.*

*Q: Okay. And is that normal practice to . . . to leave it with someone when they're not able . . .*

*A: We've done it over the past, yes.*

*Q: Okay. So he had checked on the . . . that he had personally served her, but he had indicated that she really wasn't responsive so he just tucked it in with her belongings.*

*A: Okay.*

*Q: Is that normal procedure on how to do it?*

*A: They . . . they . . . there again, I don't know. I mean I would say in that indication, yeah, probably. You know, whether . . . whether that's something that would stand up in court . . . then I mean . . . I don't know.*

In review of Sgt. Henderson's statement, he presented as not fully understanding the breadth of his responsibilities with respect to the custodians and persons in custody. I find this astounding, considering his 32 years' service with TPS. It would be easy to stop and lay blame with the on-duty NCO when issues arise in the lock-up facility. In this matter it would not be fair to stop at Sgt. Henderson. The larger responsibility rests with the Chief of Police, who must ensure that the officers he has entrusted to run and be responsible to the operations of the lock-up facility are in fact doing so according to policy and are fully aware of their duties.

#### ***d) Treatment of Victoria Rose Paul***

### **Monitoring**

#### **Provincial Standard (1992)**

*39.5.5. Detention areas for female prisoners are separate from male areas.*

*39.8.3. A written directive specifies procedures for supervision of prisoners of a sex opposite that of the supervising staff member.*

#### **Truro Police Service Standard Operating Procedures (2007)**

*D.19. Male and female prisoners can be held in same cell block area (adult side) provided no physical or visual contact can be made between prisoners. Female prisoners will be monitored by a female custodian, as soon as practicable. In the interim, male custodians can monitor female prisoners until relieved by female.*

*D.20. Whenever a female is placed in Truro Police Service cells, the monitor for that specific cell number shall only be monitored from booking screen by the on duty custodian. All other monitors in the station (dispatch, Sgt. Counter, etc.) shall be blocked out while a female is in that cell.*

*I.11. Female prisoners shall be monitored by a female custodian or female police officer whenever possible. In the event that a female staff member cannot be contacted to perform this duty, a male can act as cell guard provided due diligence is established in attempting to contact a female staff member.*

As mentioned previously, Victoria was placed in an appropriate segregated cell as defined in both the provincial standards and TPS policy. At the time of this matter, TPS did not have any female custodians (matrons) in its employ; however, there were female officers. Victoria was monitored by two (2) male custodians, and there is no evidence to suggest that a female officer was requested to monitor this female prisoner.

The provincial standard states that a specific directive needs to be in place advising staff how to monitor opposite sex prisoners. TPS policy states only that a male may monitor a female provided that due diligence is established in attempting to contact a female staff member. No attempts were made to contact a female staff member to monitor Victoria. Victoria was searched by a female officer, placed in cells by a female officer, and had her pants and undergarments pulled up by a female officer; but she was monitored by males.

Male custodians who were interviewed advised that they were not provided with any specific direction regarding the monitoring of female prisoners other than that the monitor in the booking area was to be the only area where the female prisoner should be viewed. Mr. Clyke advised:

*I don't recall there being any specific policy [re monitoring female prisoners], but I . . . myself, just when they have to use the washroom or whatnot, I don't look at the camera.*

There is a large monitor in the dispatch area. The screen for this monitor can be divided to show a number of different areas and cells at the same time. There is no way to discontinue the feed from a cell holding a female in custody to this monitor. Dispatcher Mr. Randy Hicks advised that the section with the female cell is generally blocked out with a piece of paper. Chief MacNeil confirmed this practice: "If there's a female prisoner in place there's a little card they stick up over the monitor so the whole place isn't watching the female prisoner." There is no current mechanism in place to advise dispatch that a female is in cells and to adjust their monitors. Mr. Hicks confirmed in his statement that Victoria's cell was not blocked out during her detention.

Lance Robinson, a civilian member of the RCMP with Network Services, was at the Truro Police station August 28, 2009, between 9:00 am and 12:00 pm to work on the network system. Mr. Robinson viewed Victoria from the monitor in the dispatch area:

*Q: . . . can you tell us about what you saw that day?*

*A: Well, from what I remember, in the bullpen area where the dispatchers are, they have their kind of U-shaped desk almost, and then there's a TV screen where . . . where the cells are. I can't remember how many cells there are, eight or 16 different cells, and I just remember seeing, I guess it was . . . Victoria Paul laying on the floor.*

*Q: Yes.*

*A: And it didn't look good. Didn't look right. So I . . . like we get good rapport with the dispatchers because we're there so much updating stuff, and I just mentioned to . . . seems to be like in charge I guess of the dispatcher guys, and I said that doesn't look good, kind of making conversation, kind of concerned. And he says, yeah, that person has been there all day . . . or morning. So that's all I saw the laying in . . . laying on the*



*floor. . . Just with your hands at your side and just laying there, it almost looked like she was unconscious, that's what it looked like.*

This raises a number of concerns. TPS was in breach of its policy to have female prisoners monitored only by the custodian and to have all other monitors turned off from viewing this cell. Having her cell viewed on the monitor of the dispatch area violated respect for Victoria's privacy and potentially breached confidentiality. This could potentially be said of any person in custody being viewed by staff not directly involved in the care and custody of people in the lock-up area. And furthermore, an untrained individual concluded in a matter of moments that something was wrong with Victoria.

## **Blankets, Change of Clothing, and Cell Contamination**

### **Provincial Standard (1992)**

*39.2.1. Detention facilities provide the following minimum conditions for prisoners:*

*...*

- access to . . . drinking water, a bed and bedding for each prisoner held in excess of eight hours.*

### **Truro Police Service Standard Operating Procedures (2007)**

*1.8. Should a prisoner request a mattress, blanket, or any other item, the on duty custodian will advise the on duty NCO of request. Custodian shall not supply prisoner with any item while the prisoner is in cells. Prisoners should not be given a blanket until they are observed for a minimum of three (3) hours to ensure prisoner is not a danger to themselves.*

During our interviews with custodians and officers, it was brought to our attention that it is the common practice of TPS to provide prisoners with a one-piece suit to wear when prisoners' clothing becomes soiled by bodily fluids. It is also the common practice of TPS to move prisoners to a clean cell should the occupied cell become contaminated with bodily fluids.

Prisoners detained in the Truro lock-up are required to be monitored for three (3) hours to ensure they are not a danger to themselves before being allowed to have a blanket or mattress. While this policy seems unrelated to the matter at hand, I raise it for a reason. Sgt. Henderson made the decision to place Victoria on the cement floor at 8:20 am but never provided her with a blanket or mattress. Video footage shows that these items were available outside Victoria's cell. When asked if he considered giving her a blanket, Sgt. Henderson stated "no."



Officers and custodians also informed this investigative team that it is normal practice to provide persons in custody with a one-piece suit if their clothes become contaminated. It is also normal practice to relocate prisoners to another cell if the cell becomes contaminated with such things as bodily fluids.

Victoria had unfortunately lost control of her bladder while in the care and custody of TPS. Even though Mr. Skinner noted in the log that she “has pissed her pants,” no effort was made to provide Victoria with a clean suit or move her to another cell.

When asked what happens when a prisoner soils him or herself, Mr. Clyke advised: “There are . . . suits that are there.” When asked what occurs if the cell is contaminated, he stated: “We move them [prisoners] to a clean cell.”

Sgt. Henderson and Cpl. Moore-Reid did not believe that TPS had a written protocol regarding persons in custody that may be soiled but agreed there were white suits available for prisoners to change into. Chief MacNeil confirmed this as well.

If this common practice (as told to the investigation team) had been followed, it would have provided two (2) opportunities for staff to interact with Victoria. Asking her to change her clothes and go to another cell may have made it evident to officers that Victoria was not able to do as directed. No written procedure was found in relation to this practice, but I accept it because the majority of staff indicated this is how these incidents are normally handled.

While I am not able to determine why Victoria was not provided a blanket, or why she was not provided a clean suit to wear or moved to a clean cell and left to lay in her urine, it would appear this is not the usual practice of staff at TPS. This is unacceptable and raises significant questions about the decency and respect afforded to Victoria. I am reminded yet again of Deputy Chief McNeil’s analogy of the parent-child relationship. No one would treat their child like this.

### ***e) Duty of Care***

#### **Truro Police Service Standard Operating Procedures (2007)**

*D.1. A person detained in the custody of the Truro Police Service shall be treated with decency and respect, and provided with the rights accorded to him/her by law.*

The main reason for arresting someone for public intoxication is to protect that person from harm. Chief MacNeil is of the opinion, “The only reason we arrest, though, for intoxication is to protect them from themselves. They’re incapable of looking after themselves.” This makes it necessary for the person who is intoxicated to rely on the police or the custodians for all of his or her basic needs. It also makes it

necessary for the police or the custodians to recognize that persons in custody in this state may not be able to adequately assess or ask for the required care they need because of their level of intoxication. The sentiments expressed by Deputy Chief McNeil (HRP) resonate with the analogy of a parent–child relationship. This being said, it is also important to recognize that police officers and custodians are not medical professionals and should not reasonably be expected to have the knowledge or skill set to diagnose what medical issue may be at hand or how to treat such an issue. Police officers and custodians should always err on the side of caution and call for medical assistance when there is any question of someone's alertness or well-being.

Our legal counsel, Ms. McKenna has provided me with a legal opinion of the law regarding duty of care to those in custody. In particular, I want to focus on her analysis of *Roy v. Canada* (Attorney General), 2005 Carswell BC 316:

*In Roy v. Canada (Attorney General), 2005 Carswell BC 316, the Court of Appeal, in overturning a finding of liability by the trial judge, reviewed the nature of the evidence necessary to found liability. In that case, the deceased was arrested and was not coherent at 7:16 p.m. he was delivered to cells at 7:30 p.m.; at 7:47 p.m. he was noted to be sleeping and snoring but at 7:53 p.m. he was not breathing. Emergency services were summoned and he was pronounced dead at 8:18 p.m. (approximately 1 hour after he was arrested). It appears that the cause of death was severe alcohol intoxication. It appears that the arresting officers both were of the belief that he was severely intoxicated and it did not occur to them that he was in a state of questionable consciousness when arrested. He was in the words of the court "... simply a drunk who had passed out." The trial judge, who found liability, said:*

*"... I would expect such an assessment to include, at a minimum, an attempt to converse with the person about how much he or she has had to drink, and what other causes there may be for his or her condition. I would expect some attempt to make him or her respond to basic commands to assess the level of awareness. I would expect the officer to do a basic physical examination to determine if the person has suffered any injuries, and whether the vital signs such as pulse and breathing are stable. I would also expect the officer to investigate the circumstances in which he or she was found, including speaking to available witnesses about their observations."*

*The Court of Appeal noted:*

*"2. An error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligence."*

*3. The policy of a police force is an important factor in determining the standard of care a peace officer must observe, but it is not determinative, nor is it to be treated as if it were a statute imposing civil obligations. . . .*

*4. Where, as here, at issue is the standard of a competent member of a trade or profession (and the occupation of peace officer falls within that rubric), evidence of those carrying on that occupation is necessary unless... the matter is one of "non-technical matters or those of which an ordinary person may be expected to have knowledge."*

*In overturning the decision of the trial judge the court was of the view that she had analyzed the policy as if it was a statute. The Court of Appeal noted that:*

*"... the question was whether these peace officers, acting reasonably according to the standards of their profession, ought to have recognized that Mr. Roy's condition was one of 'questionable consciousness' rather than that of the usual passed out drunk."*

There can be no question that when an individual is deprived of their liberty, there is a duty on the custodians to ensure the protection of that individual while in custody that rests not simply on the policy but on the surrounding evidence.

In this case, the facts and available information surrounding Victoria Paul included the following:

- She was fully conscious and mobile at the time of her arrest, and for a period while in custody.
- She was known to have been intoxicated.
- Initially, although she was not awakened from sleep, her sleep did not appear abnormal.
- Eventually, information was obtained that she had consumed a quart of liquor and one dozen beers.

But also:

- She fell from the bunk, leaving open the possibility of head injury.
- She lost control of her bladder.
- Her postural condition was such that it was of concern to her untrained but somewhat experienced civilian custodians.
- Her physical condition appeared to worsen rather than improve.
- No one evaluated her on the basis of the 4R's.

Aside from possible health issues, the question remains as to whether allowing Victoria to lie partially unclothed for over an hour and not to address the situation that she was lying in her own urine would constitute neglect of duty to treat her

with dignity. In review of the facts, and when you apply the principles set out in the *Roy v. Canada*, I am of the opinion that one can only conclude that there was neglect of duty in the matter before us.

## The Question of Racism

During his interview, Deveron told us that while he was being transported to the lock-up facility he argued with the officers:

*And I was yelling at them [the police] and stuff, racist slurs [directed to the officers], and they were just like, yeah, fuck you, fuck you wagon burner. Like the shit they were saying to me . . . like of all the times I ever been arrested in my life, I never ever had cops talk back to me the way they were talking back to me.*

All TPS officers interviewed were questioned about this interaction and whether anyone overheard any comments being made that were discriminatory. Officers were specifically asked if any of them called Deveron a “wagon burner.” All officers stated that they neither said the comment nor overheard it being said. The only video that has audio is in the booking area, and the video we have pertains to Victoria only. We were not able to confirm or deny the veracity of the comment.

In the matter involving a complaint under the *Human Rights Act* by Kirk Johnson against the Halifax Regional Police Service and/or Constable Michael Sanford, Mr. Johnson alleged that HRP were stopping him solely based on his race. Mr. Philip Girard in his decision discussed the influence of subconscious stereotyping:

*. . . recent decision by the Ontario Court of Appeal which raised the issue of racial profiling by the police has made it clear that discriminatory acts by the police (or anyone) can arise from a process of subconscious stereotyping as well as from conscious decisions. Thus I must be alert at all stages of the inquiry for evidence from which such stereotyping might be inferred. In R. v. Brown, [2003] O.J. No. 1251, The Court of Appeal agreed with the definition of racial profiling advanced by counsel for the police (at para. 7): “racial profiling involves the targeting of individual members of a particular racial group, on the basis of the supposed criminal propensity of the entire group.” The Court added that “the attitude underlying racial profiling is one that may be consciously or unconsciously held. That is, the police officer need not be an overt racist. His or her conduct may be based on subconscious racial stereotyping.” Brown deals with the criminal law but these comments about racial stereotyping are equally applicable in proceedings before human rights tribunals such as this one. . . The lack of courtesy towards Mr. Johnson, and the failure to make any attempt at all to investigate what the legal requirements were in an unfamiliar jurisdiction, whether through conversation*

*with Mr. Johnson or otherwise, are examples of unprofessional behaviour from which I am entitled to infer differential treatment, and I find that this differential treatment was based principally on Mr. Johnson's race. I find Constable Sanford did not display the reasonable tolerance and tact required of someone in his position and I infer that race was a major factor in this professional failing. I assume that the liability of the Halifax Regional Police would be engaged by the act of its employee pursuant to the doctrine of vicarious liability, but I also find it engaged by the failure of Sergeant Bowes to act after obtaining information that a possibly discriminatory act by one of his officers was in progress. . . Once he had that knowledge, and knowledge of the race of the parties in question, he was faced with a situation with some apparent indicators of discrimination. Under these circumstances I believe he had a duty to investigate further, and to assure himself that no discriminatory act was taking place.*

*[Johnson v Sanford and Halifax Regional Police Service (22 December 2003), NSHRT Decision, online: NSHRT <http://humanrights.gov.ns.ca/sites/default/files/files/boi-decisions/2003-Johnson.pdf>]*

From the Mi'kmaq perspective, a native woman was left to lie in her urine for hours on a cell floor while she was in distress, and Truro Police Service did not do anything to help her. Victoria told custodians she was not well, and no assistance was provided. A common statement made by the Mi'kmaq community in our meetings with them was, "You wouldn't treat your dog like that." From this community's perspective, TPS personnel were discriminatory in their behaviour toward Victoria Rose Paul and treated her in a callous manner because she was Mi'kmaq. Ms. Kimberly Paul told us, ". . . honestly my heart didn't want to believe that it was because she was Native . . . I lost my sister, it's like I lost half of my arm."

This investigation has not been able to find any conclusive evidence to support this perspective of discrimination or subconscious stereotyping. However, the investigation has shown that it was not normal practice to place and leave a person in custody on the floor for over four (4) hours, not normal practice to leave a person in custody in contaminated clothing and not offer a clean suit to change into. It was not normal practice to allow a person in custody to lie in his or her urine for an extended time; nor was it normal practice to allow a prisoner to stay in a cell that was contaminated with bodily fluids for an extended time.

## The Nova Scotia Department of Justice

The ultimate responsibility for the adequacy of policing in this province lies with the Minister of Justice under Section 5(1) of the *Police Act*. Referenced throughout this report are the standards set by the province for the care and custody of prisoners in municipal lock-up facilities. Municipal policing agencies are responsible to ensure that their policies and procedures at least adhere to the minimum standards set by the province. Also, the Nova Scotia Department of Justice requires that annual inspections be completed on each municipal lock-up facility to ensure that these minimum standards are met.

There is one (1) individual who is responsible to inspect all of the municipal lock-up facilities in the province. The inspection of a lock-up facility covers a checklist of minimum standards (Appendix I) the Department of Justice requires each facility to have. Mr. Roy Kennedy, the Policing Consultant who conducts the inspections for the Department of Justice, advised in his statement that he will ask custodians or officers, if present during the inspection, if they understand the standing orders of the facility. Mr. Kennedy admitted that most of the time when he completes his inspections, the lock-up facilities are empty of persons in custody, and therefore staff are often not around.

To have an expectation that staff will knowingly self-disclose their lack of understanding of policies or that this is a sound method to ascertain this information is not acceptable. Even if staff were to quote policies, it does not confirm that they understand them or, more important, follow them. This is not an appropriate forum to determine if custodians and officers understand operational policies. Each municipal police agency must satisfy itself on an annual basis that all staff (civilian, contract, or otherwise) are performing to the standards they have set and address any training issues accordingly.

In 2005, an inquiry into the cell death of James Guy Bailey Jr. took place. Mr. Bailey died while in the Grand Lake Road Lock-up, Cape Breton, after having been arrested under the *Liquor Control Act*. An autopsy determined that Mr. Bailey died of a drug overdose, and blood work was negative for alcohol. During the Bailey Inquiry, the current provincial standards were deemed to be lacking in sufficient areas. Recommendations from that inquiry were accepted by the former Minister of Justice, the Honorable Michael Baker. Although a committee was struck and met many times, no changes to the provincial standards were made. Rather, as mentioned previously, the inspection checklist was changed. I understand that this checklist has been enhanced in order to comply with the recommendations outlined in the report that was released on the Bailey Inquiry. Government took this approach instead of formalizing changes in regulations or updating the provincial standards.

A new provincial committee has been set up and is tasked to revisit the provincial standards. This committee includes representatives from the Department of Justice, municipal police, RCMP, municipal police boards, and RCMP advisory boards.

I believe the issues related to this investigation are of paramount importance and should receive immediate attention with the advent of this new committee. Consideration should be given to the training requirements for custodians and officers working in municipal lock-up facilities, the care and custody of prisoners, and how these facilities are evaluated.

I find it frustrating that seven (7) years after the Bailey Inquiry we are still faced with the same issues. The recommendations made in 2005 to help reduce incidents such as Victoria Paul have not been fully implemented.

TPS has had regular inspections and has been found to be in compliance with the provincial standards and has not had any reported deficiencies in staff or the operations of the facility. However, there appears to have been some confusion with respect to the purpose of the inspections and the staff it covers.

The Department of Justice needs to ensure that all municipal police agencies understand the intent of the annual inspection so further misunderstandings do not occur. It is important that the Department of Justice clarifies with municipal police departments in the province the parameters of their role in ensuring adequacy of policing in this province as set out in Section 5 of the *Police Act*.

## **Other Standards of Accountability**

From the provincial standards for municipal lock-up facilities flow policies and procedures for individual municipal police agencies. These policies set a standard of duty and care for police officers and custodians to abide by.

The *Police Act* provides a complaint process for members of the public or police agencies to follow if they have a complaint regarding a police officer. The act stipulates that a complaint must be made within six (6) months of the date of the incident that provoked the complaint. Once this time frame has expired, there is no ability to review the complaint.

The regulations pertaining to the act contain the Code of Conduct that an officer must abide by and the subsequent disciplinary defaults. Section 3 states:

*A member who neglects their duties in any of the following ways commits a disciplinary default: (a) neglecting to or, without adequate reason, failing to promptly, properly or diligently perform a duty as a member; . . . (f) neglecting or lacking concern for the health or safety of a person in the member's custody."*



On two (2) occasions, Sgt. Henderson went to see Victoria in her cell. The first occasion was at 8:16 am, the second at 12:25 pm. He advised this investigative team that Victoria could not stand unassisted, he was not able to understand her incoherent mumbles, and he never reviewed the C13-4 to see that on the first occasion she was in cells for five (5) hours and was not showing signs of improvement. On the second occasion, Sgt. Henderson did not recall going to the cell, but video footage confirms that while he was there, Victoria was lying in urine on the cell floor. At this time, Victoria had been in cells for approximately nine (9) hours—four (4) hours after he first saw her with no further indication that she was responding or sobering up. Sgt. Henderson believed Victoria was still showing signs of intoxication. With the belief that she was still drunk, Sgt. Henderson left Victoria on the cell floor and went on the road.

Sgt. Henderson has stated that an incoherent mumble and signs of breathing were indications that a person in custody was alert and therefore fit to be incarcerated. I believe that had Sgt. Henderson conducted an investigation and availed himself of the information on the C13-4, he would have concluded that Victoria's responsiveness was minimal and did not reveal "sufficient information for a police officer to reach a conclusion that [a person in custody] is conscious and not in jeopardy." (This wording originates from *Re Nielsen*, RCMP PCC, 30 October 2000, at para 38. Similar language appears in *Roy v. Canada (Attorney General)* [2000] BC. J. No. 1587, at para. 125 (QL) (S.C.). *Re Nielsen* (2000) also determined that in cases of questionable consciousness, police officers must recognize that difficulty in communication on the part of the person in custody is a symptom requiring immediate medical attention. This was confirmed by Dr. Robert Strang, NS Chief Medical Officer, in a conversation I had with him.)

In *Hill v. Hamilton-Wentworth Regional Police Services Board*, [2007] 3 SCR 129, the Supreme Court of Canada considered the standard of care of a reasonable police officer in the context of a claim for negligent investigation:

*... the general rule is that the standard of care in negligence is that of the reasonable person in similar circumstances. In cases of professional negligence, this rule is qualified by an additional principle: where the defendant has special skills and experience, the defendant must "live up to the standards possessed by persons of reasonable skill and experience in that calling"... These principles suggest the standard of the reasonable officer in like circumstances....*

*... Police meet a standard of reasonableness by merely doing what a reasonable police officer would do in the same circumstances—by living up to accepted standards of professional conduct to the extent that it is reasonable to expect in given circumstances. This seems neither unduly onerous nor overly costly.*



*Fourth, the nature and importance of police work reinforce a standard of the reasonable officer in similar circumstances. Police conduct has the capacity to seriously affect individuals by subjecting them to the full coercive power of the state and impacting on their reputations and standing in the community. It follows that police officers should perform their duties reasonably. It has thus been recognized that police work demands that society (including the courts) impose and enforce high standards on police conduct (Cory Report, at p. 10). This supports a reasonableness standard, judged in the context of a similarly situated officer. A more lenient standard is inconsistent with the standards that society and the law rightfully demand of police in the performance of their crucially important work.*

*Finally, authority supports the standard of the reasonable police officer similarly placed. The preponderance of case law dealing with professionals has applied the standard of the reasonably competent professional in like circumstances. "*

In the matter before us, was it reasonable for Sgt. Henderson to believe in these circumstances that Victoria was still showing signs of intoxication five (5) and nine (9) hours after her arrest to the point where she could not stand unassisted or communicate in any manner that made her understandable to those around her? Was it reasonable for him to believe that Victoria was fine because she was breathing and mumbled something he described as illegible?

Knowing that police officers would be held to a higher standard or duty of care, let us consider the standard for custodians. The provincial standards and the TPS policies set out a duty of care for both officers and custodians. Custodians are responsible for the care and custody of prisoners once they are placed in cells. They are required to check on them physically every 15 minutes, wake or rouse a person in custody every 30 minutes, and report any concerns regarding their well-being to the on-duty NCO, who then makes the final decision on how to proceed.

Mr. Clyke did not report to Sgt. Henderson regarding the change in Victoria's condition when she fell on the floor and advised him she was not well. However, he did advise the oncoming custodian, Mr. Skinner, that she was on the floor. There is no documentation to support Mr. Skinner's statement that he asked Victoria if she was all right and she responded "no" to him. There is considerable documentation that he was not satisfied with the results he was getting when attempting to rouse her. He reported to Sgt. Henderson that Victoria was "incoherent." As well, he further reported his concerns to Mr. White. Mr. Skinner stated:

*I told him what was happening, what my concerns were. Basically that she wasn't improving. In fact in my understanding and my expectation, she was getting worse, and I said I've never had an impaired person here who didn't get better the longer the time went. And that I . . . speaking twice, three times, whatever, to the duty Sgt., and*

*gotten a negative response each time. But I'm telling him, like I phoned him to tell him what I see because I'm concerned.*

Both Mr. Skinner and Mr. White felt Victoria was showing signs of not being well. It was both of their understandings that this needed to be reported to the on-duty NCO and that they were not in a position to call for medical assistance directly. Both of these gentlemen contacted Sgt. Henderson to advise him of their concerns.

The following is a summary of the policy considered by the Court of Appeal in *Fortey v. Canada (Attorney General)*, 1999 BCCA 314, at para. 22, combined with the statement of law in para. 36, confirming that police officers should not conduct medical assessments:

*Police officers [and custodians] are not in a position to make a medical assessment of the seriousness of an injury or the consequences that may flow from it or to determine whether treatment is urgently required. The on duty NCO must ensure that if there is any indication that a person in custody is medically unfit, the person must be examined by a qualified medical practitioner.*

*In Re Nielsen, RCMP PCC, 30 October 2000, at para 36, it was determined that if any police officers, and I would suggest it appropriate to consider custodians, have doubts concerning the need for a person in custody to have immediate medical attention, they must resolve the matter in "favor of obtaining immediate medical attention."*

The most compelling testimony this investigation has found is that from Mr. Lance Robinson. Mr. Robinson does not have day-to-day contact with or responsibility for intoxicated individuals. Mr. Robinson has no training regarding care and handling of persons in custody, how to assess someone for alertness, knowledge of the 4 R's of Rousability, or whether someone is fit to be incarcerated.

Despite this lack of knowledge, training, or daily exposure to this population, Mr. Robinson determined very quickly from a brief view on a monitor in the dispatch area that something was wrong with Victoria. Victoria Rose Paul was left in her cell for almost 10 hours before medical assistance was requested.

I have asked myself numerous times throughout this investigation what I would have done if I saw someone in Victoria's condition lying on the sidewalk. What would a reasonable person have done? My experience and my belief leads me to believe the majority of people would have stopped and asked if the person was all right, and if they could only get a response such as a grunt or groan, a call to 911 would have been made.

During the arrest and booking of Victoria, there was no evidence to support that she was not treated respectfully or with decency. Officers exercised proper use of force

when arresting Victoria, no evidence was found to suggest she was spoken to in an inappropriate manner, and she was searched by female officers.

When Sgt. Henderson became aware that Victoria was in a state of undress, he called for a female officer to rectify the situation. Sgt. Henderson's decision to place Victoria on the floor may be seen as looking out for her well-being, as he did not want her to fall off the concrete bunk and hurt herself in the fall.

The following happened during Victoria's detention at TPS:

- Victoria was partially exposed for over an hour.
- Victoria rolled out of the "recovery position" 20 seconds after being placed in that position, and she was not repositioned.
- Victoria was placed on the floor but not offered a blanket or mattress.
- The custodian noted Victoria had soiled herself, but she was not offered a clean suit.
- Victoria was not moved to a clean cell but remained in a cell contaminated with urine.
- Victoria lay in urine for over four (4) hours.
- Victoria was monitored throughout the station.
- Victoria was not properly assessed or provided medical assistance in a timely manner.

I find these instances unacceptable and appalling.

Regardless of whether custodians and officers believed Victoria was intoxicated or in medical distress, the actions described above show no consideration for Victoria's well-being or respect. We need to move from a mindset of putting someone in jail to that of a duty to care for persons in custody.

## **Part 4: Cause and Manner of Death**

The cause of death of Victoria Rose Paul was determined to have been an ischemic stroke, which was not caused by trauma or consumption of alcohol or drugs.

The medical examiner who completed the autopsy, Dr. Erik Mont, advised this team that the stroke likely took place while Victoria was in police custody and was un-survivable because of its size and location. Dr. Robert James Macauley's pathology consultation report advised that his examination of Victoria's brain confirmed the stroke was caused by a blood clot and that there were no signs of head trauma.

Dr. Mont advised that regardless of how quickly medical assistance was made available, Victoria would still have died from her stroke. This does not excuse the delay it took for Sgt. Henderson to authorize medical attention for Victoria.

As I understand from the Nova Scotia Medical Examiner's Office, the final autopsy report has recently been released. While it has taken a long time to get this report, I hope the family will find some of the answers they were seeking.

## **Part 5: Training of Officers and Custodians**

Truro Police Service prides itself in being proactive in seeking relevant training for its officers. During the calendar years of 2008 and 2009 and prior to the incident related to Victoria Rose Paul on August 28, 2009, TPS provided training opportunities for the majority of the officers involved in this matter. Officers had additional training, such as

- Recognition of Emotionally Disturbed Person
- Nova Scotia Human Rights Workshops
- Police Ethics and Accountability
- Aboriginal Awareness
- Crisis Intervention Training re Emotionally Disturbed Persons

Truro Police Service continues to be diligent in its training, and some other training has included

- Drug Awareness
- The Difference between Good and Great Supervisors
- Basic Drug Investigation Presentation
- Aboriginal Perceptions

In addition to the required training, all of these officers were required to understand the policies pertaining to Truro Police Service, and all NCOs were required to ensure that their subordinates followed these policies. Throughout this report, I have examined Truro's policies and how they flow from the provincial standards. This section will not dissect the policies but look at the level of understanding both the officers and custodians had of them, starting with the police officers.

Officers involved in the matter, including the two (2) on-duty NCOs, were asked questions about TPS policies. Questions focused on how officers determined someone was fit to be incarcerated, and their understanding of questionable

consciousness; how to rouse someone to determine his or her alertness; examination of tools such as the 4 R's of Rousability; experience with intoxicated individuals, cultural diversity, and awareness; how supervisors ensured that staff were abiding by policies; and who determined that someone required medical assistance, and how they determined it.

While officers involved had considerable training (through courses, workshops, and presentations), it was clear that there was not any site-specific training provided to them regarding the policies of the lock-up facility. My investigative team was advised that officers were expected to understand policies, but that they were not reviewed with them.

As mentioned in previous sections about how officers assessed someone to determine if he or she was fit to be incarcerated, and the completion of the C13-4, there was an inconsistent approach to these tasks. Sgt. Henderson advised in his statement:

*I don't know if there was any determination prior to 2009 . . . whether we were going to accept a prisoner, other than if they were . . . cut or bleeding or . . . needed medical attention that way. In regards to a person for intoxication, you know, that would get done on the officers I guess at the time.*

When asked how it happens now, Sgt. Henderson advised:

*I don't think there's been any new policy written in regards to who or what. I don't think there's been any . . . as far as health training in regards to determining who should go in and who shouldn't go in . . . you have your First Aid training . . . but other than in regards to the cells and prisoners coming in and out, I would say it's still the NCO or the Commissionaire in charge down there to determine who stays and who goes out.*

Sgt. Henderson did not reference the 4 R's of Rousability tool for either himself, officers, or the custodians to use in order to determine if someone was fit to be incarcerated or to assess if someone was in questionable consciousness because he told us he was not familiar with it. This despite that the 4 R's are in Truro's SOPs and that he is responsible for ensuring that staff in his charge abide by policy. However, Sgt. Henderson and the other officers were able to describe how they would try to rouse a person in custody in order to make a decision regarding the person's alertness. The unfortunate fact of the matter is that the majority of staff interviewed advised that if a person in custody was "breathing" and made any noise, whether legible or not, the person was still fit to be incarcerated. I find this an unacceptable standard to judge a person's sense of well-being.

Training regarding aboriginal perceptions and the challenges that face this community were known to the officers involved. Training in the areas of ethics and

accountability, and dealing with difficult people, was also provided. While TPS officers may have had significant training at the time of the incident involving Victoria Paul, there appears to have been a lack of due diligence, almost a complacency, toward the care and custody of apparent intoxicated individuals.

Commissionaires Nova Scotia (CNS) is a nationally recognized provider of security guards, following industry standards in this field. All individuals working for CNS complete an eight (8) day course on basic security guard services. This training is structured in accordance with the Canadian General Standards Board (CGSB) requirements. In addition to this course, CNS requires its personnel to maintain their Emergency First Aid. Site-specific training and orientation is provided at each work site by the contracting employer and is tailored to the needs of the specific detail. CNS has been providing commissionaires to the Town of Truro, and specifically Truro Police Service, since 1998. In 2009, TPS employed staff from CNS to be dispatchers and custodians for the lock-up facility. These employees were also appointed as Special Constables under the *Police Act*.

CNS provides a work-site manual to commissionaires assigned to work at TPS. This manual (2007) assists the custodians in their duties and advises them that in addition to the policies of TPS, they are also governed by the policies and procedures of CNS. The manual also lists the major job functions of guards in accordance with TPS policies and the Nova Scotia provincial standards for lock-up facilities.

Commissionaires assigned as custodians to the TPS lock-up facility receive an on-site orientation that comprises 16 hours (two 8-hour shifts) of on-the-job training from a senior custodian before being allowed to work alone. These two (2) mentoring sessions demonstrate to the new custodians how to complete the required paper-work when dealing with various offender populations (adult, youth, female inmates, prisoners from outside agencies), expose them to the behaviours of and interactions with persons in custody and, and show them how to look after these individuals once they are housed in lock-up. The new custodians are expected to review the policies and procedures of the facility during quieter times on their shifts and sign-off that they have read them and understand the policies that govern them. When interviewed, both Mr. Clyke and Mr. Skinner advised that they did not receive the full 16 hours of on-the-job training by another commissionaire.

Mr. Clyke advised:

*They showed us around the site, and we basically were showed where all of the binders with the procedures were and were asked to review them within a certain amount of time . . . Just the first shift [with a mentor] and then after that I was on my own.*

When Mr. Skinner was asked what site-specific training he received, he advised:

*They had a fellow work with me for half a shift. Basically to show me how to do my rounds and how to record things. If I hadn't been a trained chaplain for institutional work, if I hadn't have worked in a mental health hospital and an emergency ward hospital for a number of years, I don't think I could have coped because it wouldn't fit in my description of my experience. But this did. The only difference when I worked in those institutions I had more authority than I had at the jail.*

Chief MacNeil stated that the custodians are separate and are not considered staff of TPS but employees of CNS:

*The Commissionaires are not employees of us. They're contract employees, so every three years the Town of Truro tenders for lock-up services . . . And we include them in things, but at the end of the day they . . . you know, they're contract employees.*

Chief MacNeil does not believe he has a responsibility for training of the custodians other than the 16-hour orientation that is provided:

*The only thing that the Corp does now is lock-up . . . that's not our man . . . They're not my employees . . . we're not responsible for training."*

When asked if custodians or police officers were provided training for how to deal with intoxicated individuals and the difference between levels of intoxication and medical distress, Chief MacNeil stated there was no training encompassing those topics that he was aware of.

Chief MacNeil also stated that the facility is inspected annually by the province, and this inspection has not detected any shortcomings of TPS in any areas, including training. As previously discussed, these inspections include all staff, even contracted employees. Training in the areas of use of force, suicide intervention, and use of Tasers is covered in the checklist for the provincial inspection and is expected to include the custodians, whether they are contracted or direct employees. Chief MacNeil does have a duty to provide all staff with the appropriate training, including the custodians who are responsible for the care of persons in custody in the TPS lock-up facility.

Having officers, civilian staff, or contracted employees read over policies by themselves with no further review is not considered training. While there is value with peer mentoring, this type of training alone can be full of inconsistencies if there is no concerted effort to standardize the information being delivered.

Custodians are entrusted with the care and custody of prisoners. TPS has not provided adequate training of its custodians for them to carry out these responsibilities effectively. This is not a new revelation to Nova Scotia's police agencies or the



Department of Justice. The Bailey Inquiry (2005) has already made the following recommendations:

*B. The Events in the Lock-up*

- 1. Custodians must have training to adequately perform all of their duties. Experienced custodians may or may not require the same training as inexperienced custodians. Training and orientation for newly hired custodians (experienced or inexperienced) must include a review of the policies of the relevant lock-up, and those policies must be signed off within a reasonable period of time from when the custodian commences work in that lock-up.*
- 2. The employer must satisfy itself that all its employees are qualified to perform their duties. All police forces in Nova Scotia must provide the necessary training for their custodians.*
- 3. Training of custodians should include, at a minimum, note-taking, document management, suicide intervention, conflict management, intoxicated prisoner management, proper use of force, standard first aid, basic CPR, and fire prevention and control.*
- 4. Research and development must be undertaken to ensure that training for police officers and lock-up custodians is current and relevant. An example of a current issue includes the specific ability to recognize intoxication by drugs and alcohol (together and individually) as potentially lethal, as well as the general ability to effectively manage the intoxicated person.*
- 5. Lock-up supervisors (duty sergeants) should have, at a minimum, basic supervisory training and should be encouraged through financial and other incentives to pursue advanced supervisory training.*

These training needs for custodians have already been exhaustively explored, yet we are again investigating another similar situation, coming to similar findings and conclusions, all at a considerable cost to taxpayers. The Bailey Inquiry recommendations apply to the matter before us.

I am of the view, after reviewing the cell videos of Victoria Rose Paul and all the other evidence, that any reasonable person would have concluded she was in medical distress long before medical assistance was offered. While there is a gap in training, no amount of training will compensate for a lack of judgment. Nevertheless, I would encourage all municipal police agencies to ensure that all of their staff, including custodians, are adequately trained and understand their duties and responsibilities to persons in custody.



## Part 6: Truro Police Service Response to Matter

### Truro Police Service Standard Operating Procedures (2007)

*C.5. The Truro Police Service Major Crime Unit is responsible for the investigation of any significant incident or serious criminal complaints in the Lockup Facility.*

*C.6. In the event of a prisoner's death while in custody of the Truro Police Service Lockup, Nova Scotia Police and Public Safety shall be notified as soon as practicable, as per Department of Justice Standing Orders for Lockup Facilities.*

The province of Nova Scotia has assembled a new civilian-led investigative body that will be responsible to investigate serious incidents, death, sexual assault, and other public-interest concerns involving police officers. The Serious Incident Response Team (SIRT) became operational in April 2012. In the future, this team would investigate matters such as Victoria Rose Paul's case.

In the absence of such a team and approach, police agencies had been responsible to investigate these incidents themselves. Chief MacNeil is a strong supporter of the SIRT and believes this is an important step forward to help resolve such matters as Victoria's in a more appropriate manner:

*I don't like police investigating police. I never have. And I'd be one of the more vocal chiefs in the Province pushing for an independent agency . . . to take on that role.*

Chief MacNeil became aware, through the media, that Victoria's condition had deteriorated and that she was transported to the QEII in Halifax. He contacted Halifax Regional Police to review the incident to determine if any wrongdoing or policy breaches occurred. HRP conducted an operational review of the incident and submitted a report to Chief MacNeil.

This operational review and report will be examined later in this report.

Victoria's death was not considered a cell death, as she was released from the care and custody of TPS prior to her death. Mr. Robert Purcell, executive director, and Mr. Fred Sanford, director, of the Police and Public Safety Division of the Department of Justice became aware of the matter through the media; they contacted Chief MacNeil to see if he required anything. Chief MacNeil advised Mr. Purcell and Mr. Sanford that he had asked HRP to conduct a review and would let them know once it was concluded.

Chief MacNeil contacted Ms. Kimberly Paul, Victoria's sister, on September 2, 2009, to advise her that he had requested HRP to do an independent review of the matter. He did not have a lot of information to relay to her at this time, as HRP was just beginning to set up its team. Chief MacNeil contacted Ms. Paul again on

September 8, 2009, to confirm that HRP was doing a review. Victoria had died on September 5, 2009.

Ms. Paul told this investigation team:

*... he was concerned [Mr. Skinner]. But like if she wasn't responding and stuff, like why didn't they call then? Why they wait so long, like I mean if they call quicker we probably wouldn't have lost her ... honestly that's what's really (pause) that's the only question that bugs me.*

Chief MacNeil indicated that Ms. Paul did not mention any intention to file a complaint but wanted an answer to why it took so long for officers to make a call for medical assistance. Chief MacNeil advised Ms. Paul that the review by HRP was ongoing and would hopefully provide some answers. Chief MacNeil also advised this team that he tried to contact Ms. Paul again on September 9, 2009, but was not able to reach her.

Ms. Paul went to the station on September 14, 2009, and spoke with Deputy Chief Terry Flemming looking for answers to what happened to her sister. Deputy Chief Flemming advised Ms. Paul that he was not involved in the matter and provided her with the contact information of Detective Constable James Luther, HRP, to speak with him about her concerns.

HRP concluded its review in October 2010. The biggest delay in concluding the manner was the long wait for the toxicology report. I understand that it is not unusual to wait almost a year for these types of reports.

Superintendent Spicer directly provided the report and findings to Chief MacNeil. Chief MacNeil stated that he needed time to review the report and meet with his board. On December 3, 2010, a meeting took place in Indian Brook with Kimberly Paul, Cheryl Maloney, Chief MacNeil, and Staff Sergeant Randy MacKenzie to discuss the report and provide the family with a vetted copy in accordance with the requirements of Freedom of Information and Protection of Privacy legislation.

Chief MacNeil described the meeting as unproductive and stated that there was no further contact with the family.

Deveron Paul advised that the only contact he had with TPS regarding his mother was when he was in cells August 28, 2009.

Kimberly Paul advised that she had limited contact with TPS and did not find it of any benefit.

There are no statutory requirements or policies outlining communications with a family for incidents such as this. When Victoria Rose Paul, an adult, was arrested and held for public intoxication, there was no obligation on TPS to contact her family.

As well, there was no requirement for TPS to contact the family when Victoria was transported to Colchester Regional Hospital. Victoria did not die in police custody, and therefore there was no obligation to contact the next of kin. Once she was at the hospital, nursing staff there contacted Victoria's family to advise them of her location and condition.

While I am of the opinion that Chief McNeil did all he could to communicate with the family, it is important that agencies such as SIRT consider how they communicate with families in these matters.

## **Part 7: Halifax Regional Police Investigation**

My understanding is that HRP conducted an operational review of the circumstances surrounding the death of Victoria Rose Paul. This preliminary review was to see if there were enough grounds to go forward with an investigation, under either the Criminal Code or the *Police Act*. If any evidence was found to support an investigation under either statute, Chief MacNeil would have been advised and Truro would request a new team to commence the investigation. Chief MacNeil stated:

*So I asked Halifax to come up and do an operational [re]view, which is basically just of review of the . . . incident in its entirety, ensure we followed our policy and procedures. And if there was somebody or someone that didn't do something they were supposed to, then I would expect that the review would see. Somebody would say, oh, Chief, you know, there could be a Police Act matter here, and then . . . we would follow . . . whatever . . . came up out of the review.*

Superintendent Spicer confirmed this in his statement:

*. . . our purpose was to do an operational review and that's it, but if something became apparent during that review that there was either a violation of the Criminal Code or even the Police Act of the Province of Nova Scotia, then the focus would have changed . . . And then it would have to be an actual investigation conducted after that . . . usually the operational review team and the investigative team wouldn't be the same necessarily, but quite often the protocol in Nova Scotia is that if there's a death in cells or serious incident that has the need for investigation, then a different agency does it.*

Superintendent Don Spicer was assigned as the lead for the review. He assembled a team of four (4) officers to assist him. Team members included Staff Sergeant Darrell Gaudet, Detective Constable James Luther, Detective Constable Steve Waterfield, and Detective Constable Steve McCormack. Detective Constables Luther, Waterfield, and McCormack were tasked to interview all civilian witnesses at the scene of arrest. Detective Constable Luther was also the case manager for the file. Staff Sergeant Gaudet and Superintendent Spicer interviewed Mr. Skinner and all officers involved in the matter.

The statements from civilian witnesses were very thorough. Deveron Paul was not interviewed because HRP did not consider him to be pertinent to the case.

Although Mr. Clyde and HRP confirmed that he was interviewed, a statement could not be found; nor was any mention of his involvement included in the report. Mr. White, the dispatcher who requested medical assistance for Victoria, and the arresting officer, Constable D'Entremont, were not interviewed. The interviews conducted on the officers did not cover such things as the time Victoria was in cells, how Victoria was assessed, the explanation of the decline in her behaviour, how the on-duty NCO determined that Victoria did not require medical assistance, why she was allowed to stay on the floor lying in urine for so long, or if the on-duty NCO provided any directions to his staff regarding Victoria. There was no examination of officer knowledge of the 4 R's of Rousability, questionable consciousness, or how staff rouse persons in custody to assess their alertness.

It appears that HRP's primary focus was to determine if police involvement or an incident during the arrest caused Victoria's stroke. In concluding remarks on the case management system used by HRP, D/Cst. Waterfield states:

*The Police investigation revealed no signs of physical injury to the Victim. The results of the Autopsy support this finding. Cause of death has been determined to be natural (see autopsy report). The file will be close [sic].*

The date on this entry is December 30, 2009. Once the evidence and medical report concluded that Victoria died of natural causes, there was no further review or investigation as to the level of care afforded to Victoria while she was in cells.

HRP concluded that there were no breaches in policies or statutes. HRP concluded that there was no need for an investigation under the Criminal Code of Canada or the *Police Act*, but nothing substantive to support these findings was clearly documented. The interview with Sgt. Henderson was not thorough enough to reasonably conclude anything with respect to any potential wrongdoing on his part or if an investigation would be warranted under the *Police Act*. However, by the time the file was concluded, the six (6) month statutory requirement to file a complaint under the *Police Act* had already expired.

The following recommendations put forward to Chief MacNeil in the HRP report are sound and practical:

1. *Review current department policy which requires all prisoners exhibiting signs of any illness or pain to be evaluated by medical personnel only with approval of Duty NCO.*

*Current policy does not give any control to the booking officer. All responsibility is directed toward the duty NCO. The Duty NCO is also in-charge of the day to day operations on the road. Decisions in relation to medical attention should be directed to those working directly with the prisoners. The booking officer has no authority in calling EHS, and yet the booking officer is tasked with the well-being of prisoners.*

2. *Review department training on injury assessment provided to booking officers and Duty NCOs*

*Properly trained booking officers/Duty NCOs would provide an efficient and effective injury assessment of all prisoners. An assessment of the current skills of the booking officers and Duty NCO on the assessment of injuries should be conducted. Ensure that all members and civilian guards have a solid and continuing knowledge and understanding of the operational policy dealing with medical assistance for detainees.*

3. *Provide training to all operational members, and Civilians who deal with prisoners.*

*To assist them in recognizing if persons in their custody need immediate medical assistance. Such training should ensure, among other things that members can use and understand a straightforward assessment aid and check list similar to the Glasgow Coma Score and/or the Metropolitan Police Service [London, England] policy commonly known as the '4 R's of Rousability'. The officer in charge should ensure that all civilian guards are given access to training of this type contemplated above. Post a straightforward assessment aid and check list similar to the Glasgow Coma Score and/or the Metropolitan Police Service policy commonly known as the '4 R's of Rousability' in a conspicuous location in the guardroom and/or booking area.*

4. *Assessment of Intoxicated Prisoners*

*That the Truro Police Service adopt a similar 'rousability' policy as the RCMP that includes a physical check (by entering cell) of prisoners with questionable consciousness or extreme intoxication every hour to assess their condition. Regular and random monitoring for quality assurance should be conducted by senior members of the Truro Police Service. 'Questionable consciousness' means a state of reduced awareness in which a person is not readily responsive.*

5. *Prisoner review by on coming NCO*

*Recommend that on coming NCO or designate at shift change be required to do a physical cell check together with booking officer, and review incident reports and medical requirements of each prisoner.*

*That the Truro Police consider the following: In cases where paramedics and/or police believe that an intoxication or other illness has impaired the person's ability*

*to make a rational decision regarding the need for medical treatment that the common law permits the person to be transported for medical treatment.*

Despite the fact that HRP's review had a narrower focus than my investigation, there are similarities in the recommendations. I had some difficulty, however, in understanding how they concluded that these changes were required in the absence of any findings of wrongdoing.

In the absence of SIRT, chiefs of police were left with no legislated process to guide them in whom to contact or how the matter should be handled. All municipal police agencies faced this situation and had established the practice of not directly investigating themselves internally but having an outside municipal agency, or sometimes an out-of-province agency, investigate the matter. HRP and the RCMP do have a memorandum of agreement for an Integrated Critical Incident Team, which sets out an agreement and parameters for investigations of serious incidents involving members; no other such agreements exist in the province.

The request by Chief MacNeil was not outside the accepted practice within the province to have an outside municipal agency investigate an internal incident. Chief MacNeil determined that HRP likely had sufficient resources to deploy to Truro because of its size. The HRP officer whom Chief MacNeil would need to contact to set this up was the Deputy Chief of Operations, Chris McNeil. These two men are distant relatives. HRP was able to accommodate the request, and Deputy Chief McNeil assigned the investigation to Superintendent Spicer. Superintendent Spicer selected his team, and Deputy Chief McNeil had nothing further to do with the file. Once the review was completed, Superintendent Spicer submitted his report directly to the Truro Chief of Police.

There is no evidence that a prejudiced approach was used in requesting HRP to conduct this investigation, or of an actual conflict of interest. However, Victoria Rose Paul's family and the Mi'kmaq community have raised concerns about the impartiality of HRP's review. The perception was that Chief MacNeil hand-selected the police agency he wanted to do the investigation and that if any information regarding potential wrongdoing was brought to his attention, he was the sole person to determine what would happen next. The fact that Chief MacNeil and Deputy Chief McNeil are related cast further suspicion on the process, from the Mi'kmaq perspective.

While Chief MacNeil's decision to ask HRP to conduct this review was sound—and I do not believe there was an actual conflict of interest—I agree that there is a perceived conflict of interest. I also believe that no matter which agency Chief MacNeil contacted or how competent the investigation was, there would still be

the perception that he chose the agency to do the investigation, and it is still police investigating police. I know from my experience in civilian oversight that this has been the only option available to police. Hopefully, the new SIRT will alleviate this public perception.

## **Part 8: Conclusion**

After careful consideration of all the facts and evidence set out above, I can answer the questions the Minister of Justice has asked me to investigate as follows.

*I. Whether the Truro Police Service complied with all appropriate training, policies, procedures, guidelines, Nova Scotia statutes and regulations, and the Criminal Code (Canada) in relation to the events of August 28, 2009, from the moment Victoria Paul was arrested and detained for public intoxication to the time an ambulance arrived to respond to Ms. Paul.*

My investigation has shown that Truro Police Service did not comply with all appropriate training, policies, procedures, or guidelines in relation to the events of August 28, 2009, with respect to Victoria Paul. TPS did not provide adequate training for its officers or custodians regarding policies pertaining to assessments or dealing with medical issues of persons in custody. Officers and custodians need to be provided with the skills and training necessary for them to deal efficiently and competently with the individuals who end up in custody. At a minimum, custodians need specific training in the use of force, suicide intervention, when to call for medical assistance, and dealing with challenging or intoxicated individuals. TPS police officers also need to be provided with a more appropriate review of the policies and a sign-off indicating that they understand these policies, similar to what is currently in place for the custodians.

Custodians in all provincial lock-up facilities in Nova Scotia are tasked with the care and responsibility of persons in custody. These individuals have first-hand knowledge of a prisoner's well-being and should be able to judge the care needs of the person in custody. It is only reasonable that the person who has the direct responsibility and knowledge of the circumstances should be making these decisions. I am pleased to see that TPS has clarified its policy stating that custodians are able to call for medical assistance on their own volition. However, more work has to be done in this area of policy. In review of the lock-up policies of other municipal police agencies, I have noted a similar concern and would encourage all agencies to review current practice.

TPS policies meet the minimum requirements, and in some cases exceed provincial standards for lock-up facilities. I do find that the provincial standards



require updating and clarity. However, the issues at hand are judgment related rather than functions of policy or deficiencies in training. Sgt. Henderson, as the on-duty NCO, exercised poor judgement and neglected his duties on August 28, 2009.

This investigation has found that there were many inconsistent practices and confusion among officers and custodians with respect to carrying out their duties at the lock-up facility. All employees need to clearly understand their roles and responsibilities in order to carry out their duties to the best of their professional ability. TPS needs to review these roles and responsibilities with all employees.

No one filed a complaint or initiated an investigation pursuant to the *Police Act* against any members of the Truro Police Service. The chief of police of any agency is able to initiate an investigation into one of his or her members if the situation warrants. I believe an internal investigation should have taken place in accordance with the *Police Act* regarding Sgt. Henderson's conduct on August 28, 2009. This is not to conclude or suggest the findings of such an investigation, only that it would have been prudent to have conducted one before the six (6) month time frame to file a complaint expired. The *Police Act* does not allow the Police Complaints Commissioner to initiate his or her own investigation, as other oversight bodies do. This could be an area government might want to examine.

*II. Whether the Truro Police Service provided appropriate monitoring of Ms. Paul's health and access to a medical assessment in a timely manner.*

Truro Police Service did not appropriately monitor Victoria Rose Paul's health; nor did it provide access to a medical assessment in a timely fashion.

The number of checks completed on Victoria was in accordance to policy. As discussed at length, the quality of these checks, or further direction in policy on how to conduct an appropriate check, was lacking. That being said, Mr. Skinner knew fairly early in his shift that something was wrong with Victoria. We also have Mr. Robinson, an IT worker, who recognized very quickly that something was wrong with the person in custody he saw on the monitor.

Sgt. Henderson advised us during this investigation that he did not see anything that would indicate to him that Victoria was in medical distress, but his experience led him to believe she was still intoxicated. However, Sgt. Henderson did not consider all the facts of the matter before reaching this conclusion. I do not accept the commonly held belief that just because Victoria was breathing she was fine. I do not accept that Victoria continued to be fit to be incarcerated when she needed to be held by a number of officers in order to have her undergarments and pants pulled up and fastened, when she displayed no comprehensible



conversation with officers or custodians, or when she was placed on the floor where she remained for several more hours in urine. Medical attention should have been sought well before 1:00 pm.

*III. Whether the Truro Police Service appropriately communicated with Ms. Paul's family having regard to all appropriate training, policies, procedures and guidelines.*

In review of the facts and evidence before me, I conclude that TPS did communicate appropriately with the Paul family. Chief MacNeil spoke with the family, before Victoria's death, to advise of his decision to have an outside agency review the matter. The decision to initiate an external review was not driven by a complaint but by the Chief's belief that it was better to deal with the matter proactively. While communication was limited, Chief MacNeil did speak with the family and made arrangements for the Pauls and Ms. Maloney to have a vetted copy of the report concluded by HRP. There is no evidence to suggest that Chief MacNeil did not make either himself or members of his staff available should the Pauls have any questions.

*IV. Whether the Truro Police Service policies, procedures and guidelines relating to the manner in which it detains, monitors and responds to intoxicated persons, are adequate.*

Truro Police Service policies, procedures, and guidelines pertaining to intoxicated individuals need to be enhanced. Initial and ongoing assessments of persons in custody, completion of the C13-4, adequate sharing of information between shifts and with custodians, assessing the need for medical assistance, and clearly identifying who is the decision maker regarding the care needs of persons in custody need further development within TPS policies.

I think it is only fair to point out that this matter extends beyond TPS and must have a province-wide application. While my terms of reference do not extend to a review of any of the other municipals lock-ups, I would strongly encourage all municipal police agencies to review their policies in light of this report and make the appropriate changes.

*V. Whether the investigation by the Halifax Regional Police into Ms. Paul's death was adequate, performed faithfully and impartially, and free of actual or perceived conflict of interest or bias.*

With respect to the adequacy of the HRP investigation, it is difficult to fairly judge owing to the lack of clear terms of reference. One can argue that HRP adequately investigated the very narrowest of focuses: that is, whether the TPS did anything to cause her death during her arrest or during her time in the cell. However, their investigation of the broader issues was less thorough. Relevant parties—such as Deveron Paul, Cst. D'Entremont, and Mr. White—were not interviewed.

While there may have been an investigation of how Victoria was treated during her detention, or why medical attention was not sought until after she was in cells for over 10 hours, the documentation of the investigation does not show how the team reached its conclusions and recommendations.

I do conclude that Halifax Regional Police performed its investigation faithfully and impartially. I do not find any evidence to suggest bias or a conflict of interest. However, there is a perceived conflict of interest in that Chief MacNeil selected the agency of his choosing, although his reasons for selecting HRP were sound. With the Serious Incident Response Team now operational, it is hoped that public perception of these investigations will improve.

I would point out, however, that an issue remains with regard to the time limits set out in the *Police Act*. While the amendments to the *Police Act* direct SIRT to refer a conduct issue back to the officer's department or the Office of the Police Complaints Commissioner, any such investigations might not be completed within six (6) months, as was the case here. The fact that the family was not able to file a public complaint after HRP issued its report contributed significantly to their lack of confidence in the system of civilian oversight in this province.

Unfortunately, there have been numerous instances across the country where individuals die or suffer medical trauma while in police custody. There is nothing we could put in place that would eliminate these instances fully, but it is critical that we improve existing standards, training, and policies to help reduce these tragic occurrences. However, common sense must prevail, and if someone in custody appears to be in medical distress, it is always in the best interest of everyone to err on the side of caution and provide the person with immediate access to professional medical personnel.

## Part 9: Findings

I have made the following findings:

1. Truro Police Service failed to appropriately monitor Victoria Rose Paul's health and provide her access to medical assistance in a timely manner.
2. Truro Police Service failed to provide Victoria Rose Paul with respect and dignity during her detention in the lock-up facility August 28, 2009.
3. There is no medical evidence to suggest that Victoria Rose Paul's stroke was caused by any trauma during her arrest or detention.
4. Truro Police Service had reasonable and probable grounds to arrest Victoria Rose Paul under Section 87(1) of the *Liquor Control Act*.
5. Truro Police Service did appropriately segregate Victoria Rose Paul from male persons in custody and ensured that she was searched by female officers.
6. Truro Police Service policies regarding assessment of persons in custody (initial and ongoing), medical requirements of persons in custody, sharing of prisoner information at shift changes, proper completion of the C13-4, and proper documentation need to be enhanced.
7. Truro Police Service officers demonstrated inconsistent practices regarding proper completion of the C13-4, assessments of persons in custody (initial and ongoing), and sharing of prisoner information at shift changes.
8. Truro Police Service is responsible to provide proper training to contracted employees that are responsible for the care of persons in custody detained in Truro's lock-up facility.
9. Truro Police Service has not provided officers or custodians sufficient training in policies and procedures regarding the care and custody of prisoners.
10. Truro Police Services failed to ensure that Victoria Rose Paul was monitored in accordance with policies pertaining to female persons in custody.
11. Mr. Skinner failed to report to the on-duty NCO that Victoria Rose Paul had lost control of her bladder and was lying in bodily fluid for an excessive time.
12. Truro Police Service has no written policy regarding cell contamination and providing persons in custody with sanitary suits.
13. Sgt. Henderson failed to avail himself of all the information available to him in order to appropriately assess Victoria Rose Paul's condition, thereby failing to provide her with medical attention in a timely manner.

14. Sgt. Henderson neglected his duties and made significant errors of judgment.
15. The established attitude in Truro Police Service that if a person in custody “is breathing they are fine” is unacceptable.
16. There was no independent investigative body, such as the new Serious Incident Response Team, to handle this matter at the time.
17. Chief MacNeil acted within the established provincial practice when he requested Halifax Regional Police to conduct the review of the matter pertaining to Victoria Rose Paul.
18. There was a perceived conflict of interest with Truro Police Service requesting that Halifax Regional Police investigate the matter pertaining to Victoria Rose Paul.
19. The Halifax Regional Police investigation of the matter pertaining to Victoria Rose Paul was very narrow in focus.
20. Provincial standards for lock-up facilities require updating and clarification.
21. The Nova Scotia Department of Justice needs to examine its inspection process for lock-up facilities and clearly communicate to municipal police agencies the intent of the inspection.

## Part 10: Recommendations

Based on the above findings I make the following recommendations:

1. Truro Police Service amend policies to ensure that clear direction is provided to officers and custodians regarding initial and ongoing assessments of persons in custody, consistent completion and review of the C13-4, how information is to be documented and communicated between shifts, providing medical assistance, and clear roles and responsibilities of all individuals working in the lock-up facility.
2. Truro Police Service develop and implement a review mechanism to ensure that all staff are following a consistent approach when assessing persons in custody before placement in cells; that quality checks are done to ensure continued fitness to be incarcerated; and that adequate documentation of required forms is being done.
3. Truro Police Service to provide officers and custodians adequate on-site training in order for these employees to sufficiently carry out their duties. This training should include at a minimum proper training on the policies and provincial standards of the care and custody of prisoners, how to interact with challenging or intoxicated individuals, conflict resolution, suicide intervention, use of force, how to conduct quality checks on persons in custody, and how to determine whether medical assistance is required.
4. Truro Police Service review and enhance its orientation for custodians.
5. Truro Police Service provide officers and custodians tools such as the 4R's of Rousability and to post in plain view such guides to assessing persons in custody.
6. Truro Police Services adopt definitions in policy regarding questionable consciousness, prisoner alertness, and well-being.
7. Truro Police Service provide all officers, civilian staff, and custodians sensitivity and cultural awareness training.
8. Truro Police Service address the attitude among lock-up personnel that a person in custody only needs to be breathing to be all right.
9. Truro Police Service provide Sgt. Henderson with further supervision training and review of the policies to ensure that he understands and is fulfilling his duties as required with respect to the lock-up facility and his subordinate staff.

10. Truro Police Service review its performance management process to ensure that the performance of all staff, including contract employees, is appropriately addressed.
11. Truro Police Service develop policy regarding cell contamination and providing clean, sanitary suits for persons in custody to wear.
12. Nova Scotia Department of Justice update and clarify the provincial standards for lock-up facilities.
13. Nova Scotia Department of Justice clarify with all municipal police agencies in the province that have lock-up facilities the role and purpose of the annual inspection of such facilities.

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## **Appendices**

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## **Appendix A**

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### **MINISTERIAL ORDER**

Pursuant to Section 7 of the *Police Act*, S.N.S., 2004, c. 31

**WHEREAS** Victoria Paul was arrested by the Truro Police Service on August 28, 2009 for public intoxication, and was taken to the Truro Police Lock-Up Facility.

**AND WHEREAS** Ms. Paul was taken in an ambulance from the Truro Police Lock-Up Facility to the Colchester Regional Hospital later in the day of August 28, 2009.

**AND WHEREAS** Ms. Paul was transferred to the Queen Elizabeth II Hospital in Halifax, N.S., where she passed away on September 5, 2009.

**AND WHEREAS** the Halifax Regional Police was requested by the Truro Police Service to conduct an operational review into the circumstances surrounding Ms. Paul's death, including her arrest and detention.

**AND WHEREAS** the Halifax Regional Police conducted an operational review and concluded that there was no violation of the *Criminal Code* or other federal, provincial or municipal statute.

**AND WHEREAS** the public, Ms. Paul's family and the Aboriginal community, including the Nova Scotia Native Women's Association, have expressed concerns to the Minister of Justice and the Premier, who is the Minister responsible for Aboriginal Affairs, and have requested an independent process to review the actions of the Truro Police Service.

**AND WHEREAS** in February, 2011 a resolution supporting an inquiry into the detention of Ms. Paul was passed by the Atlantic Policy Congress of First Nations Chiefs.

**AND WHEREAS** the Minister of Justice has determined that an independent investigation of the circumstances of Ms. Paul's arrest, confinement and transfer to hospital is appropriate in the circumstances.

**IT IS HEREBY ORDERED**, in accordance with Section 7 of the *Police Act*, which allows the Minister of Justice to order an investigation into any matter relating to policing and law enforcement in the Province, including an investigation respecting the operation and administration of a police department, that Nadine Cooper- Mont conduct an investigation and provide a written report to me, with recommendations if they are deemed appropriate.

**IT IS ORDERED** that the scope of the investigation is to investigate the following:

- Whether the Truro Police Service complied with all appropriate training, policies, procedures, guidelines, Nova Scotia statutes and regulations, and the *Criminal Code (Canada)* in relation to the events of August 28, 2009, from the moment Victoria Paul was

arrested and detained for public intoxication to the time an ambulance arrived to respond to Ms. Paul;

- Whether the Truro Police Service provided appropriate monitoring of Ms. Paul's health and access to a medical assessment in a timely manner;
- Whether the Truro Police Service appropriately communicated with Ms. Paul's family having regard to all applicable training, policies, procedures and guidelines;
- Whether the Truro Police Service policies, procedures and guidelines relating to the manner in which it detains, monitors and responds to intoxicated persons, are adequate; and
- Whether the investigation by the Halifax Regional Police into Ms. Paul's death was adequate, performed faithfully and impartially, and free of actual or perceived conflict of interest or bias.

**IT IS ORDERED** that the written investigation report with recommendations, if appropriate, be provided to me by March 1, 2012, with the option for a 3 month extension with my approval.

In accordance with subsection 7(5) of the *Police Act*, the persons conducting this investigation have all of the powers and immunities of a peace officer during the investigation and any proceedings relating to this matter under investigation.

**DATED** this 25<sup>th</sup> day of August, 2011, Halifax Regional Municipality, Province of Nova Scotia.

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the bottom.

Ross Landry  
Minister of Justice and Attorney General

### MINISTERIAL APPOINTMENT

Pursuant to Section 7 of the *Police Act*, S.N.S., 2004, c. 31

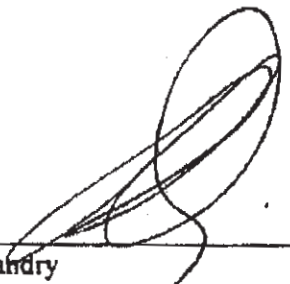
**WHEREAS** subsection 7(3) of the *Police Act* allows the Minister of Justice to appoint a person with technical or other specialized knowledge to assist a person conducting an investigation pursuant to subsection 7(1) of the *Police Act*.

**AND WHEREAS** in an Order dated August 25, 2011, attached hereto as Schedule "A", I have ordered that Nadine Cooper- Mont conduct an investigation under Section 7 of the *Police Act*.

**I HEREBY APPOINT** Deborah Maloney to assist Ms. Cooper-Mont in an observation and advisory role due to her knowledge and expertise of the Mi'kmaq community and culture, and her experience and role in the justice system.

The Roles and Responsibilities of this Appointment are set out in Schedule "B" attached hereto.

**DATED** this 7<sup>th</sup> day of September, 2011, Halifax Regional Municipality, Province of Nova Scotia.

  
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Ross Landry  
Minister of Justice and Attorney General

### **MINISTERIAL APPOINTMENT**

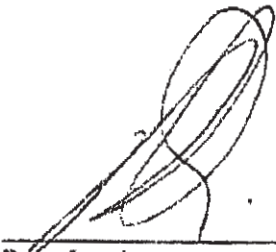
Pursuant to Section 7 of the *Police Act*, S.N.S., 2004, c. 31

**WHEREAS** subsection 7(3) of the *Police Act* allows the Minister of Justice to appoint a person with technical or other specialized knowledge to assist a person conducting an investigation pursuant to subsection 7(1) of the *Police Act*.

**AND WHEREAS** in an Order dated August 25, 2011, attached hereto as Schedule "A", I have ordered that Nadine Cooper- Mont conduct an investigation under Section 7 of the *Police Act*.

**I HEREBY APPOINT** Jennifer Innis as an investigator to assist Ms. Cooper-Mont, due to her investigative skills and experience.

**DATED** this 7<sup>th</sup> day of September, 2011, Halifax Regional Municipality, Province of Nova Scotia.



Ross Landry  
Minister of Justice and Attorney General

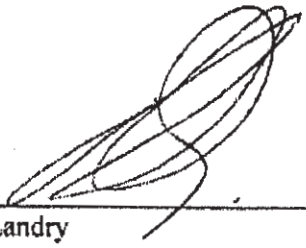
**MINISTERIAL APPOINTMENT**  
Pursuant to Section 7 of the *Police Act*, S.N.S., 2004, c. 31

**WHEREAS** subsection 7(3) of the *Police Act* allows the Minister of Justice to appoint a person with technical or other specialized knowledge to assist a person conducting an investigation pursuant to subsection 7(1) of the *Police Act*.

**AND WHEREAS** in an Order dated August 25, 2011, attached hereto as Schedule "A", I have ordered that Nadine Cooper- Mont conduct an investigation under Section 7 of the *Police Act*.

**I HEREBY APPOINT** Anthony Penny as an investigator to assist Ms. Cooper-Mont, due to his investigative skills and experience.

**DATED** this 7<sup>th</sup> day of September, 2011, Halifax Regional Municipality, Province of Nova Scotia.

  
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Ross Landry  
Minister of Justice and Attorney General

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## **Appendix B**

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Nadine Cooper Mont is the Police Complaints Commissioner for the Province of N.S. She is responsible for civilian oversight of all municipal Police Departments in the province and has served in this position since 2001. From 1987 to 1993 she was the Deputy Minister of the N.S. Department of the Solicitor General, responsible for policing and corrections. During that time she implemented recommendations from the Commission into the Wrongful Conviction of Donald Marshall and oversaw the establishment of the Unama'ki Police Force for reserves in Cape Breton. She has a BA, LLB, and a Masters in Public Administration from Dalhousie University.

Jennifer Innis has been an investigator within the Nova Scotia provincial government for over 16 years. She has experience in an oversight capacity with the Nova Scotia Office of the Ombudsman, conducting complex investigations involving allegations of government wrongdoing, maladministration of the law, breaches in ethics and code of conduct, harassment, and bullying in the workplace. Prior to this, Jennifer has been responsible for assessing client eligibility requirements for the Nova Scotia Department of Community Services' financial assistance program, through a lens to review situations of potential fraud. Jennifer has a BA from Acadia University, a Masters in Adult Education from St. Francis Xavier University, and is a Certified Fraud Examiner.

Tony Penney has over 32 years of policing experience with the RCMP and was seconded to the Unama'ki Tribal Police for 3 years when it was initially set up in Cape Breton. He has a BA from St Francis Xavier University. He has been a part time investigator for the Office of the Police Complaints Commissioner for the past 10 years.

Cpl. Deborah Maloney is from the Mi'kmaq First Nation in Indian Brook, Nova Scotia. She has been a police officer with the RCMP for over 25 years, in both British Columbia and Nova Scotia. In her professional role as Aboriginal Policing Analyst, she liaises with Aboriginal Leaders and Community, Federal, Provincial and Municipal agencies, community groups and individuals to ensure the development of programs that reflect the Aboriginal view on issues related to providing police services. In her personal life, Debbie has had the fortune of being raised by parents who instilled within her a strong sense of self identify as a Mi'kmaw woman. She pays tribute to her Mi'kmaq Elders, Mentors, women and friends who have helped guide and support her in the traditional way of life.

Jean McKenna is a partner with the law firm of Ritch Durnford. She is a former Vice Chair of the NS Police Review Board and served as Legal Counsel to the Bailey and Richard Inquiries. She has an extensive practice in the area of civil litigation involving policing issues and is an investigator for the New Brunswick Police Commission.



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## **Appendix C**

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## Victoria Paul Investigation

### Interviews and Meetings

Name	Position	Police Service	Interview Date
Jean McKenna	Legal Counsel for Investigation	N/A	September 12, 2011
Frank Beazley & Martin Ward	Chief of Police & Legal Counsel	Halifax	October 11, 2011
Dave MacNeil & David Fisher	Chief of Police & PANS Legal Counsel	Truro	October 11, 2011
Ms. Cheryl Maloney, the Paul Family, Respected Elders of Indian Brook	Mi'kmaq Community	N/A	October 12, 2011
Rob Hearn	Inspector	Truro	October 21, 2011
Shaun Joseph & Site Visit	Manager Warehouse Bar	Truro	October 21, 2011
Deveron Paul	Son of Victoria Paul	N/A	October 25, 2011
Rob Hearn	Inspector	Truro	October 25, 2011
Jim Skinner	Former Custodian	Truro	November 1, 2011
Randy Hicks	Dispatcher	Truro	November 3, 2011
Gordie Clyde	Former Custodian	Truro	November 3, 2011
Don Spicer, Steve Waterfield, James Luther, & Darrell Gaudet.	HRP Investigative Team	Halifax	November 7, 2011
Lance Robinson	Civilian Member RCMP (Network Services)	N/A	November 7, 2011
Kimberly Paul	Sister of Victoria Paul	N/A	November 8, 2011
Dr. Eric Mont	Medical Examiner	N/A	November 10, 2011
Steven Julian	Victoria's Father	N/A	November 16, 2011
Cheryl Maloney	Executive Director of NS Native Women's Assoc.	N/A	November 16, 2011
Gerard White	Dispatcher	Truro	November 17, 2011
Matthew Starratt	Paramedic EHS Truro	N/A	November 17, 2011
Kelly Quinn	Constable	Truro	November 22, 2011
Kevin D'Entremont	Constable	Truro	November 22, 2011
Rob Hunka	Detective Constable	Truro	November 22, 2011
Rick Hickcox	Constable	Truro	November 24, 2011
Ashley Volans	Paramedic EHS Truro	N/A	November 27, 2011
Dave MacNeil	Chief	Truro	November 28, 2011
Lee Henderson	Sergeant	Truro	December 1, 2011
Kelly Moore-Reid	Former Corporal TPS	Truro	December 5, 2011
Greg Densmore	Constable	Truro	December 5, 2011
Don Spicer	Superintendent	Halifax	December 6, 2011

Darrell Gaudet	Staff Sergeant	Halifax	December 6, 2011
Chris McNeil	Deputy Chief	Halifax	December 7, 2011
Roy Kennedy	Lock-up Inspector Dept. of Justice Public Safety	N/A	December 9, 2011
Monica Veinott (Garland)	Former Constable TPS	Truro	December 9, 2011
Dave MacNeil, Terry Flemming, & Randy MacKenzie	Chief, Deputy Chief, & Staff Sergeant	Truro	December 13, 2011
Steve Waterfield	Detective Constable	Halifax	December 14, 2011
Steve McCormack	Detective Constable	Halifax	December 14, 2011
James Luther	Detective Constable	Halifax	December 14, 2011
Members of the Paul Family & Community		N/A	December 15, 2011
Dave MacNeil & Rob Hearn	Chief & Inspector	Truro	January 16, 2012
Paula Marshall	Executive Director Mi'kmaq Legal Support Network	N/A	January 23, 2012
Community Members of Indian Brook		N/A	January 24, 2012
Robert Purcell & Fred Sanford	Executive Director & Director Public Safety Division Dept. Justice	N/A	February 3, 2012
Geoff Green	Former Constable TPS	Truro	February 6, 2012
Kimberly Paul & Community Members		N/A	February 23, 2012
Ernest Walker & Denise Moore	Executive Director & Coordinator, Aboriginal & Intergovernmental Relations Aboriginal Affairs	N/A	February 29, 2012
Cheryl Maloney	Executive Director of NS Native Women's Assoc.	N/A	March 14, 2012

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## **Appendix D**

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## **The Police Act**

### **Section 5 Duties of Minister**

5(1) The Minister shall ensure that an adequate and effective level of policing is maintained throughout the Province.

### **Section 7 Minister may order investigation into policing**

7 (1) Notwithstanding anything contained in this Act, the Minister may order an investigation into any matter relating to policing and law enforcement in the Province, including an investigation respecting the operation and administration of a police department.

(2) An investigation pursuant to subsection (1) shall be conducted by such person and in such manner as the Minister may specify in the order and that person shall provide the Minister with

(a) a written report; and

(b) recommendations, where appropriate,

within the time frame specified by the Minister.

(3) The Minister may appoint a person with technical or other specialized knowledge to assist the person conducting an investigation pursuant to subsection (1).

(4) Upon receipt of a report pursuant to subsection (2), the Minister may take whatever action the Minister considers appropriate to implement any recommendations provided pursuant to clause (2)(b).

(5) A person conducting an investigation authorized by this Section has all of the powers and immunities of a peace officer during the investigation and any proceedings relating to the matter under investigation. *2004, c. 31, s. 7.*

## **Police Regulations**

### **Code of Conduct**

**24 (3)** A member who neglects their duties in any of the following ways commits a disciplinary default:

(a) neglecting to or, without adequate reason, failing to promptly, properly or diligently perform a duty as a member;

(f) neglecting or lacking concern for the health or safety of a person in the member's custody.

## **The Liquor Control Act**

### **Section 87 Public intoxication prohibited**

87 (1) No person shall be in an intoxicated condition in a public place.

(2) Where an officer has reasonable and probable grounds to believe a person is in an intoxicated condition in a public place, the officer may, instead of charging the person under the Act, take the person into custody to be dealt with in accordance with this Section.

(3) A person taken into custody pursuant to this Section may be taken by the officer to any available treatment service, hostel or facility for care.

(4) A person arrested or taken into custody pursuant to this Section shall not be held in custody in a jail or lock-up for more than twenty-four hours after being arrested or taken into custody.

(5) A person taken by an officer to any treatment service, hostel or facility for care shall not be detained there for more than twenty-four hours after he was taken into custody unless the person consents to remain for a longer period.

(6) A person taken into custody pursuant to this Section may be released from custody at any time if

(a) the person in custody has recovered sufficient capacity that, if released, he is unlikely to cause injury to himself or be a danger, nuisance or a disturbance to others; or

(b) a person capable of doing so undertakes to take care of the person in custody upon his release. *R.S., c. 260, s. 87.*

### **Section 10 Court Houses and Lockup Houses Act**

#### **Keeper**

10 Every lockup house shall be placed in charge of a constable or police officer specially designated for that purpose and the keeper shall be responsible for the safe custody of prisoners confined therein. *R.S., c. 109, s. 10.*

## Chapter 39

### DETENTION FACILITY

These standards apply only to those departments operating short-term detention facilities to maintain custody of prisoners for short periods.

#### Management

- 39.1.1** The department has a written directive that governs the operation and maintenance of the detention facility.

*Comments: The written directive may be in the form of a manual that covers management, operations, security, prisoner accounting, and control. (M M M)*

- 39.1.2** A written directive designates one person as responsible for the operation of the detention facility.

*Comments: It is important for successful operation of the facility that one person be held responsible for the facility's operation, including management of its personnel, prisoners, and programs. (M M M)*

- 39.1.3** A written directive governs access of nonessential persons to the detention facility.

*Comments: The directive should address access to the facility by counsel, family and others. (M M M)*

#### Physical Plant

- 39.2.1** Detention facilities provide the following minimum conditions for prisoners:

- o sufficient lighting;
- o circulation of fresh air in accordance with local public health standards;
- o access to a toilet, wash basin or shower, and drinking water; and
- o a bed and bedding for each prisoner held in excess of eight hours.

*Comments: The directive may provide exceptions for prisoners who are deemed to be suicidal. (M M M)*



**39.3 Safety and Sanitation**

**39.3.1 A written directive prescribes fire prevention practices and procedures for the facility.**

*Comments: The department should plan and execute all reasonable procedures for the prevention and prompt control of fire.  
(M M M)*

**39.3.2 The type and location of fire equipment is approved in writing by provincial or local fire officials.**

*Comments: Fire equipment should be located in easily accessible locations affording minimum opportunity for tampering.  
(M M M)*

**39.3.3 A written directive requires a documented weekly inspection and a documented semiannual testing of fire equipment.**

*Comments: The inspection should focus on verifying the presence of equipment and detecting any tampering or damage.  
(M M M)*

**39.3.4 The facility has an automatic fire alarm and heat and smoke detection system that are approved in writing by provincial or local fire officials.**

*Comments: The facility should have the capability to alert staff to the presence of both fire and smoke in the facility. The fire alarm system should be connected directly to the nearest full-time, emergency dispatch centre. (M M M)*

**39.3.5 A written directive requires weekly inspection and documented monthly testing of the facility's automatic fire detection devices and alarm system.**

*Comments: Automatic devices, shall be tested to determine that they are functional. (M M M)*

**39.3.6 There is a written and posted emergency evacuation plan for the facility and a designated and signed emergency exit directing evacuation of persons to hazard-free areas.**

*Comments: If possible, two separate means of emergency exit should be provided. The evacuation plan should specify route of evacuation and subsequent disposition and housing of prisoners. The plan also should include provisions for first aid and hospital transportation. (M M M)*



- 39.3.7 A written directive requires a sanitation inspection of the facility and specifies procedures for control of vermin and pests.**

*Comments: Any condition conducive to harbouring or breeding insects, rodents, or other vermin should be eliminated. (M M M)*

#### **Security and Control**

- 39.4.1 A written directive specifies that firearms will be secured before anyone enters the detention facility.**

*Comments: Exceptions to the standard may be made in certain emergency situations. (M M M)*

- 39.4.2 A written directive requires a security check, including searching for weapons, prior to each use of an unoccupied cell.**

*Comments: A security check, including a search for weapons, should be made of each unoccupied cell prior to use. (M M M)*

- 39.4.3 A written directive requires a documented security inspection, including searching for weapons, of the detention facility at least weekly.**

*Comments: All detention areas and other areas to which prisoners have access should be searched for weapons and other prohibited articles. (M M M)*

- 39.4.4 There is a security alarm system linked to a designated control point.**

*Comments: Emergency alarm systems are vital to the safety of prisoners and staff and to the security of the facility. (M M M)*

- 39.4.5 A written directive prescribes procedures to be followed in the event of an escape.**

*Comments: The procedures to be followed if an escape occurs should be made known to all personnel. (M M M)*

#### **Prisoner Processing**

- 39.5.1 A written directive requires that a search be made of all prisoners before entry into the detention facility and that a written, itemized inventory be made of all property taken from a prisoner.**

*Comments: The written directive should specify which items may be retained by the prisoner. (M M M)*

**39.5.2 A written directive requires the secure storage of any property taken from prisoners.**

*Comments: Secure storage facilities should be available for prisoners' property or any other items that prisoners have in their possession at time of arrest. (M M M)*

**39.5.3 A booking form is completed for every person booked into the facility and contains the following information:**

- o arrest information;
- o apparent physical condition; and
- o property inventory and disposition.

*Comments: Booking information should enhance the ability of the facility staff to promote conditions that contribute positively to the health and security of the prisoner, to the safety of others, to the security of property, and to the positive identification of the prisoner. (M M M)*

**39.5.4 Young offender detention areas are separate from adult detention areas.**

*Comments: Young offender detention areas should be separated from adult areas. (M M M)*

**39.5.5 Detention areas for female prisoners are separate from male areas.**

*Comments: Female detention areas should be separated from male detention areas. (M M M)*

**39.5.6 A written directive prescribes methods for handling, detaining, and segregating persons under the influence of alcohol or other drugs or who are violent or self-destructive.**

*Comments: The detention facility is not normally equipped to provide treatment to persons under the influence of drugs or alcohol, and such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensuring that the potential for prisoners to injure themselves or others is minimized. Such prisoners should remain under close observation by facility staff. (M M M)*

**39.5.7 A written directive prescribes space arrangements and procedures to follow in the event of a group arrest that exceeds the maximum capacity of the detention facility.**

**Comments:** *The directive should address such matters as provision for extra personnel, additional physical facilities, and booking and detention procedures. (M M M)*

- 39.5.8** A written directive governs the return of property to prisoners upon release.

**Comments:** *Property should be compared with the inventory list and the prisoner should sign a receipt for property returned. Property retained for evidentiary or other purposes should be noted on the receipt. (M M M)*

#### **Medical and Health Care Services**

- 39.6.1** A written directive identifies the policies and procedures to be followed when a prisoner is in need of medical assistance.

**Comments:** *The intent of this standard is to ensure that staff recognize, take immediate action on, and report all prisoner medical emergencies. (M M M)*

- 39.6.2** A first aid kit is available in all facilities and is subjected to a documented inspection and replenished, as necessary.

**Comments:** *First aid equipment available to facility personnel should provide a capability for proper response to a broad range of anticipated emergencies. (M M M)*

- 39.6.3** If the department dispenses pharmaceuticals, a written directive governs distribution and documentation of those pharmaceuticals within the facility.

**Comments:** *Proper distribution of pharmaceuticals includes procedures for administering labelled drugs and controlled substances. (M M M)*

#### **Prisoner Rights**

- 39.7.1** A written directive requires that a prisoner's opportunity to make bail is not impeded.

**Comments:** *The intent of this standard is to ensure compliance with the Criminal Code and the Charter of Rights and Freedoms. (M M M)*

- 39.7.2** A written directive ensures confidential access to counsel.

**Comments:** *Every effort should be made to ensure privacy in contacts between counsel and their clients. (M M M)*

**39.7.3** A written directive sets forth procedures for a prisoner's access to a telephone.

*Comments: Any limits on the use of the telephone, such as the type and number of calls and their duration, should be stated.  
(M M M)*

**39.7.4** Three meals are provided to all prisoners in the facility during each 24-hour period.

*Comments: No more than 14 hours should elapse between meals, except when a different dietary regimen is medically indicated.  
(M M M)*

## **39.8** Supervision of Prisoners

**39.8.1** A written directive requires 24-hour supervision of prisoners by department staff, including a count of the prisoner population at least once per shift.

*Comments: Twenty-four-hour supervision is essential for maintaining security and ensuring the safety and welfare of prisoners.  
(M M M)*

**39.8.2** A written directive requires that each prisoner be visually observed by department staff at least every 30 minutes.

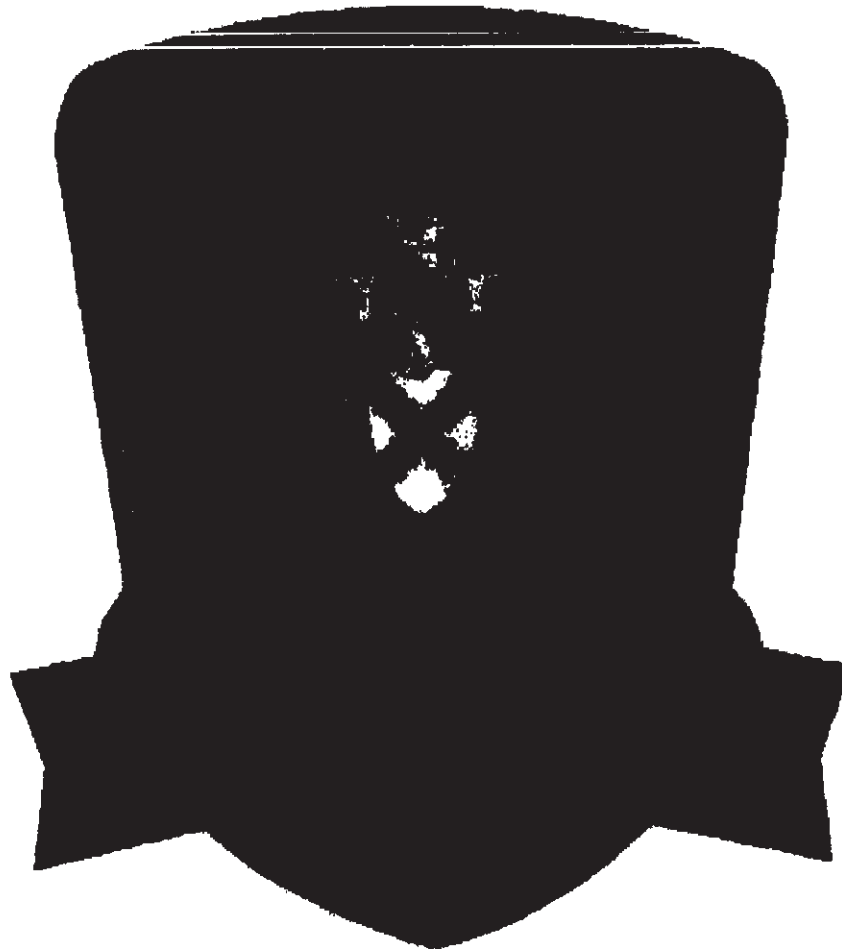
*Comments: Prisoners who are security risks should be under closer surveillance and may require more frequent observation.  
(M M M)*

**39.8.3** A written directive specifies procedures for supervision of prisoners of a sex opposite that of the supervising staff member.

*Comments: It is inappropriate for staff to supervise prisoners of the opposite sex; department staff should be carefully advised of procedures to be followed in these instances when the appropriate staff are not available. (M M M)*

**39.8.4** A written directive governs prisoners' visitation rights and prescribes procedures for registering visitors to the facility and for searching visitors.

*Comments: Prisoners should be permitted visitors consistent with security needs and operational considerations. (M M M)*



**Truro Police Service  
Standing Operational Procedures  
Part XII - Lock-Up Facility**

Revised: December 5, 2007

**A. Subject:**

This Chapter deals with procedures to be followed in the booking, supervising and the releasing of all prisoners held in the Lock up Facilities of the Truro Police Service.

**B. References:**

1. Criminal Code of Canada
2. Youth Criminal Justice Act (YCJA)
3. Identification of Criminals Act
4. Nova Scotia Department of Justice Standing Orders for Lockup Facilities
5. Canadian Charter of Rights and Freedoms
6. Children's Ombudsman Province of Nova Scotia
7. United Nations Convention on The Rights of the Child

**C. General :**

1. The Truro Police Service Lockup Facility will be staffed by personnel appointed by the Chief of Police or designate.
2. The N.C.O. on duty shall be designated as the officer in charge in order to fulfill procedures defined by Sec 493 Criminal Code of Canada.
3. The N.C.O. on duty or designate shall be responsible for the Lock up Facilities.
4. Personnel employed in the Lock up Facility shall report any incident involving injury, property damage, illness, or failure of equipment under their control to the on duty N.C.O. The supervising N.C.O. shall report any major incident to the Chief of Police or D/C of Police.
5. The Truro Police Service Major Crime Unit is responsible for the investigation of any significant incident or serious criminal complaints in the Lockup Facility.
6. In the event of a prisoner's death while in the custody of the Truro Police Service Lockup, Nova Scotia Police and Public Safety shall be notified as soon as practicable, as per Department of Justice Standing Orders for Lockup Facilities.

**D. Booking :**

1. A person detained in the custody of the Truro Police Service shall be treated with decency and respect, and provided with all the rights accorded to him / her by law.
2. No smoking shall be permitted in or near the cell block area.



3. A Prisoner Report Form C13 will be completed by the arresting member on each person arrested and held in cells. Arresting officer will also enter prisoners name in the prisoner log book located in booking. ( See Appendix A )

4. The arresting member will conduct a personal search of all persons arrested to remove any item that could be used by the prisoner to cause harm to themselves, as well as to secure and protect personal property. If a prisoner is a female, the search shall be conducted by female custodian or female police officer.

\*2 5. The arresting officer will list; all items removed from the prisoner, on the Prisoner Report form, and will store these items in the secure lockers located in the Cell Block area until such time as the prisoner is released.

6. Any item seized from the prisoner, which could be used as evidence, will be recorded on a Truro Police Service Property / Exhibit Report Form, and processed as per Standard Operational Procedures.

7. All prisoners held in custody at Truro Police Service Lock up will be checked on CPIC for warrants, CNI history, and PROS computer records. Such checks shall be noted on the Prisoner Report Form.

8. The health of the prisoner, including any injury, or medical alert bracelets shall be determined prior to him/her being placed in the cells. Should any serious injury, illness(epileptic, heart condition) be known, or the prisoner require any medication, the arresting officer shall ensure the N.C.O. on duty is immediately notified and the person taken, by ambulance to be examined at Colchester Regional Hospital before admission to Lockup. Should the on duty N.C.O. feel there is no immediate threat to the prisoners life, transport can be provided by police, but only in non - emergency situations.

9. Prisoners shall not be in possession of medication while in Truro Police Service cells.

2 10. At any time during incarceration, should a prisoner complain of a medical problem or the need for medication, the on duty N.C.O. shall be notified and the prisoner be taken by ambulance to Colchester Regional Hospital for examination.

5 11. Individuals who are brought into custody in a state of apparent sleep or unconsciousness must be woke prior to being placed in a cell. The 4R's of rousability model should be used as a guide when attempting to assess a prisoners level of rousability. ( See Appendix F) If the arresting officer is unable to wake the individual, he /she will be immediately transported to hospital by ambulance to be examined by a physician.

12. The on duty N.C.O. will be advised of individuals in a state of apparent intoxication who have a known history of drug overdose, a medical history that may be associated with an altered level of consciousness (diabetes), or a history of significant head trauma. These individuals shall be examined by a physician prior to being held in Lockup.

⑨

13. An individual who is detained in Lockup for intoxication shall be woken every 30 minutes and assessed for alertness.

14. The on duty N.C.O. will be advised if at anytime a prisoner is not able to be woken, or is unconscious. The prisoner shall be immediately taken by ambulance to Colchester Regional Hospital.

15. The arresting officer is responsible for placing the detained person in the cell prior to departing Lockup.

16. No firearms are permitted in the cells. Should a member be required to enter a cell for any reason, their firearm shall be secured in a designated firearm locker.

17. The Truro Police Service Lockup has the capability of handling a total of fourteen prisoners at any given time. The individual cells 1,2,3,4,6,7, shall hold only one prisoner at a time, with cell 5, having an authorized maximum capacity of eight prisoners at any given time.

18. Should the Truro Police Service Lockup reach the maximum capacity of fourteen prisoners, the on duty N.C.O. shall be advised and shall review the status of all prisoners with the purpose of determining if any prisoners can be safely released.

19. Male and female prisoners can be held in same cell block area ( adult side ) provided no physical or visual contact can be made between prisoners. Female prisoners will be monitored by a female custodian, as soon as practicable. In the interim, male custodians can monitor female prisoners until relieved by female.

20. Whenever a female is placed in Truro Police Service cells, the monitor for that specific cell number shall only be monitored from booking screen by the on duty custodian. All other monitors in the station ( dispatch, Sgt. counter etc.) shall be blacked out while a female is in that cell.



**E. Prisoners from other agencies:**

1. If a prisoner is being held for another agency ( RCMP, Sheriff, other P.S.) The arresting agency or escorting member of that agency is to complete a Prisoner Report form C13, or equivalent, prior to the prisoner being accepted by our agency. ( See Appendix A )

2. Prior to admission, the prisoner is to be searched by the arresting officer who is also responsible for securing items taken, as per Section D, para 5.

3. Prisoners from other agencies remain the responsibility of that agency. Their representative is to be contacted by the on duty N.C.O. if an emergency or illness arises with their prisoner. To prevent any delay, the Truro Police Service will take immediate action in cases of injury or illness, pending arrival of the responsible agency.

4

4. During the booking process for an other agencies prisoner, the jail custodian will sign the prisoner report form as the person taking over, noting from what agency the prisoner is from, and time booked into Truro Police Service Lockup.

5

5. If there are any signs of illness or injury at the time of admission the member of the arresting agency will be responsible to transport the prisoner for appropriate medical treatment prior to prisoner being accepted to Truro Police Service Lockup.

6

6. Do not accept any prisoner from another agency until you are satisfied that appropriate medical attention has been obtained by the arresting agency.

7. Should an other agencies prisoner become ill or injured in the Truro Police Service Lockup, the prisoner will be immediately transported by ambulance to hospital. The arresting agency will be notified by on duty N.C.O. and requested to attend hospital to take over security of prisoner and make a decision on the prisoners continued detention.

8. The prisoner of another agency shall be released from Truro Police Service Lockup by a member of the arresting agency.

**F. Telephone Calls:**

1. It is incumbent that any person being arrested or detained be provided with the means of making a telephone call(s) in private to retain and instruct counsel as provided under Sec. 10(B) Canadian Charter of Rights and Freedoms.

2. The holding room located in booking will be used for this purpose. The arresting officer is to assist prisoner in contacting counsel.

3. Where a long distance call is requested by prisoner it shall be a collect call, unless otherwise approved by the on duty N.C.O.

4. The arresting officer shall ensure all prisoner phone calls are logged in the Prisoner telephone log book, located in booking, listing date, time, number and name of person called.

5. Persons in an intoxicated condition shall be provided with the opportunity to telephone legal counsel upon demand provided that their state of sobriety is such that the request can be facilitated without potential difficulty or safety concerns for the prisoner, or arresting officers.

#### **G. Meals :**

8

1. Prisoners who are held in custody for offences under the Criminal Code, C.D.S.A. or warrants, etc. will be provided a meal, if they are detained over a designated meal period. All prisoners held overnight in Truro Police Service Lockup will be fed in the morning prior to being taken to court.

2. Soft drink bottles, or cans, glass containers, and / or cutlery are not permitted in the cells as they could be used as a weapon.

3. Prisoners meals will be obtained from the Subway Court St. A member will be assigned by the on duty N.C.O. to obtain, and sign for the prisoners meal at Subway. The member will obtain a receipt from Subway, will initial the receipt and give it to the lockup custodian.

4. The Lockup custodian will record all meal times on the Prisoner Log sheet.

#### **H. Young Offender :**

1. Every effort shall be made to house Young Offenders separate from adult prisoners in the designated Young Offenders cells 6, and 7.

2. A Prisoner Report Form C13, and a Young Offender Detention Form is to be completed by the arresting officer, prior to young person being placed in cells. ( See Appendix B )

3. The arresting officer shall notify the young persons parents, guardian, or other responsible adult that the child is in police custody as per the YCJA.

4. Any young person detained in the custody of the Truro Police Service shall be informed of their right to contact the Children's Ombudsman and provided with the phone number 1- 888 - 839 - 6884. This notification shall be recorded on the Young Offender Detention Form.

5. Any young person held in custody shall be notified that a blanket is available should one be required. This notification shall be recorded on the Young Offender Detention Form.

6. All female young persons shall be advised that feminine protection ( sanitary napkins) are available should one be required during their stay. This notification shall be recorded on Young Offender Detention Form.

**I. Guard / Custodian Duties :**

1. If present when prisoner is being booked into Truro Police Service Lockup, the custodian will assist arresting officer in completing Prisoner Report Form, and provide any other form the arresting officer may require from booking counter.

2. The custodian will immediately start a Log Sheet noting prisoners name, condition, date, time, and cell number the prisoner is placed. ( See Appendix C)

3. The custodian will be given the original Prisoner Report Form which will be attached to the Prisoners Log sheet. The custodian on duty at time of release shall ensure these documents are filed in cabinet marked Lockups located next to booking counter.

9 4. The on duty custodian shall physically check each prisoner at least every fifteen minutes, or more frequent should conditions such as mental stability, or intoxication dictate. The times of these checks, and actions of prisoner shall be recorded on Log sheet.

10 5. The on duty custodian shall observe the monitors located at the booking counter during the time between physical checks of prisoners, and record any pertinent observations on Log sheet.

6. When the prisoner is detained for intoxication, the custodian shall wake the prisoner every thirty minutes. If the prisoner is unable to be woken, the N.C.O. shall be immediately notified, and an ambulance requested.

7. Should a prisoner complain of any illness, injury, or a suicide attempt be made, the on duty N.C.O. shall be notified immediately and medical aid provided as soon as possible.

11

8. Should a prisoner request a mattress, blanket, or any other item, the on duty custodian will advise the on duty N.C.O. of request. Custodian shall not supply prisoner with any item while the prisoner is in cells. Prisoners should not be given a blanket until they are observed for a minimum of three(3) hours to ensure prisoner is not a danger to themselves.

9. Once a prisoner is released, the on duty custodian will physically search the cell, recording property found, or any damage noted. This shall be documented on the Prisoner Log sheet. Anything noted will be reported to the on duty N.C.O. immediately by the custodian.

10. At the start of each shift the on duty custodian shall check the Lock up equipment drawer ensuring all items listed on equipment inventory are present. Should any item be absent from this drawer, the custodian will notify the on duty N.C.O. ( see Appendix D)

11. Female prisoners shall be monitored by a female custodian or female police officer whenever possible. In the event that a female staff member cannot be contacted to perform this duty, a male can act as cell guard provided due diligence is established in attempting to contact a female staff member.

12. If the on duty custodian requires additional assistance in monitoring numerous prisoners they shall advise the on duty N.C.O. who will assess the requirement for additional staff.

12

13. The on duty custodian shall remain in the cell block area at all times, unless they are relieved by another custodian or a police officer. The on duty custodian must first be given permission from the on duty N.C.O. to leave the cell block area.

14. The on duty custodian shall ensure all keys for the Lockup are in their possession at all times when prisoners are in cell block. Lockup keys shall not be left on desk, or counter where prisoner may have access to keys.

15. When the lockup is not in use, cell keys are to be stored in equipment drawer next to booking counter.

16. The spare cell key is located in the key storage cabinet in dispatch. This key is only to be removed by the on duty N.C.O. in the event of emergency.

**J. Fire / Cell Evacuation :**

1. In the event of a fire in the cell block, the on duty custodian shall sound the fire alarm system, and immediately notify the on duty N.C.O. and if necessary take appropriate action to ensure safety of prisoners and staff. This may include temporarily relocating prisoners to another part of the building, or exiting building.
2. Should the Truro Police Service cell block be evacuated for any reason, the on duty N.C.O. will contact Bible Hill R.C.M.P. and immediately transport prisoners to Bible Hill R.C.M.P. Detachment 287 Pictou Rd. cells, as per Letter of Understanding. ( See Appendix E)
3. In circumstances other than fire the on duty N.C.O. will determine when the cell block shall be evacuated.
4. In the event of a fire in Truro Police Service Lockup, the Provincial Fire Marshall's office shall be notified as soon as practicable.
5. The Truro Police Service Lockup shall be inspected on an annual basis by the Provincial Fire Marshall's Office.

**K. Duty N.C.O. :**

1. The on duty N.C.O. is responsible for the operation of the Truro Police Service Lock up during the course of their shift.
2. When prisoners are being held during the course of their shift, the on duty N.C.O. shall ensure all staff comply with the policies outlined in the Standard Operational Manual.
3. The on duty N.C.O. shall visit the cell block area at least once during the shift, and record visit on the Prisoners log sheet.
4. The on duty N.C.O. shall ensure no prisoner is held beyond the twenty four hour period without having prisoner appear before a Justice of the Peace or taken to Provincial Court.
5. If a prisoner is held beyond your shift, the on duty N.C.O. shall brief the incoming shift N.C.O. on the status of all prisoners being held and the terms of their release.

**L. Release of Prisoners :**

1. All persons shall be released from the Truro Police Service Lockup according to release provisions of the Criminal Code of Canada.
2. The on duty N.C.O. shall be designated as the officer in charge in order to fulfill procedures defined by Sec. 493 Criminal Code of Canada.
3. The on duty N.C.O. shall ensure prisoners are served with all appropriate court documents prior to being released from custody.
4. Upon releasing prisoner, the N.C.O., or designate, shall return all seized property directly to the prisoner. The prisoner must sign Prisoner Report Form acknowledging return of property.
5. The on duty N.C.O. is responsible for ensuring prisoners held in custody are taken to Provincial Court as required.
6. Prisoners held in custody will be encouraged to make transportation arrangements upon their release. ( taxi, friend, relative etc.) On duty N.C.O. will ensure prisoner has access to a telephone for this purpose.
7. In the case of intoxicated persons, the on duty N.C.O. shall release as soon as practicable, considering state of persons intoxication.

**M. Prisoner Escape from Custody :**

1. In the event of an escape from the Truro Police Service Lock-up the on duty N.C.O. will be immediately advised.
2. Dispatch shall immediately advise all patrol units to be on look out for escapee via police radio. Subjects name, physical description, clothing, and direction of travel shall be given to patrol units as soon as available.
3. Truro Police Service K-9 Unit shall be summoned to the scene of the escape to assist in tracking / apprehending the escapee.
4. R.C.M.P. Telecoms shall be advised of escape and subjects name, physical description, clothing, and direction of travel provided should the escapee enter the R.C.M.P. jurisdiction.
5. Dispatcher shall as soon as possible add the escapee to C.P.I.C. and fan out province wide.

6. The on duty N.C.O. shall notify the Chief of Police, or Deputy Chief of Police of an escape from the Truro Police Service Lock -up.

**N. Visitation of Prisoners**

1. There shall be no visitors permitted in the Lock up area while prisoner(s) are in cells.
2. Should a prisoner need to meet with counsel during their stay in Lock up, the N.C.O. on duty shall be advised to approve this request. The secure holding room in the cell block shall be utilized for this purpose, and a police officer is to observe such a meeting through the window of secure holding room. Upon completion of meeting, the prisoner will be searched prior to being placed back in cell. Counsel shall only be permitted visitation to the Lock up under emergency circumstances.

**O. Release of Prisoner Information :**

1. The on duty N.C.O. is the only person permitted to release information regarding a prisoner in Lock up.
2. Information released shall not be sensitive, or pertain to any charges or matters before the courts. The rights of the prisoner must not be violated by the information released.
3. Information regarding prisoner shall only be released to a confirmed family member.
4. Information released will be restricted to confirmation of subject's identity and future disposition, i.e. : court appearance, remand, warrant for other jurisdiction.

**P. Non - release of Prisoner :**

1. Should a prisoner not be released from Lock up under provision of the Criminal Code of Canada, the on duty N.C.O. shall be responsible for ensuring the prisoner is transported to Provincial Court as required.
2. Should a prisoner be remanded while in Lock up, the on duty N.C.O. shall be responsible to ensure the Nova Scotia Sheriff's Department is notified, and transportation to a Correctional Facility is arranged via Sheriff's Department as soon as practicable.



3. If a prisoner is held in Lock up for a Federal Parole violation, or Parole Warrant, the on duty N.C.O. shall immediately notify Correctional Services Canada, and obtain a copy of the parole warrant. The on duty N.C.O. shall arrange transportation for the prisoner through the Nova Scotia Sheriff's Department as soon as practicable.

4. The on duty N.C.O. shall ensure all documentation is provided to the Sheriff's Department when they are transporting a prisoner from Truro Police Service Lock up. This shall include but is not limited to copies of warrants, and prisoner medical form.

**Q. Bomb Threats :**

1. Should the Truro Police Service Lock up receive a bomb threat the on duty N.C.O. shall be notified immediately to assess the threat, and take any action required to ensure safety of staff, and of prisoners.

2. The on duty N.C.O. shall notify the Chief of Police or Deputy Chief of Police of any bomb threat directed at Truro Police Station located at 776 Prince St. Truro, this would also include the Truro Police Lock up.

3. Should the Truro Police Service cell block be evacuated for any reason the on duty N.C.O. will contact the Bible Hill R.C.M.P. and immediately transport prisoners to Bible Hill R.C.M.P. Detachment cells, 287 Pictou Rd, as per Letter of Agreement. ( See Appendix A )

4. The Truro Police Service Major Crime Unit will be responsible for investigating any bomb threats directed at Truro Police Service facilities.

5. Should bomb detection / bomb disposal expertise be required contact numbers are located in dispatch under B -2 of dispatch directory.

**R . Closed Circuit Video Cameras :**

1. The video equipment for the cell block shall be checked every 24 hours to ensure all cameras are functioning properly.

2. The on duty dispatcher shall be responsible for checking the digital recording equipment every other Monday to ensure the equipment is recording the cell block. A log of these checks will be kept in the Dispatch.

3. Should any problems with video recording equipment be noted, the on duty N.C.O. shall be immediately advised.



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## **Appendix E**

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### Occurrence summary

HCMP GRC/Truro NS PS

Printed: 2011/10/31 09:17 by E00000247

Occurrence: **20091010762 Failure to comply with condition of undertaking or recognizance / direction in remand order 145(3) CC (FIP) @2009/08/28 03:00**

Date/Time: between.... 2009/08/28 02:58 and 2009/08/28 03:15

Clearance status: Cleared by charge/charge recommended

Involved person(s):

- 1) [Assisted organization] WAREHOUSE FOOD&BEVERAGE EMPORIUM (76 INGLIS PLACE S, TRURO, COLCHESTER COUNTY NS Canada (WAREHOUSE) (Dist: EPPA, Det: Truro NS PS, Zone: 1) (Voice) (902) 897-7482)
- 2) [Charged] PAUL, VICTORIA ROSE [DECEASED] 1965/09/30 (46) F (565 CHURCH STREET, INDIAN BROOK, HANTS COUNTY NS Canada (Div: H, Dist: Indian Brook, Det: Indian Brook, FN reserve: INDIAN BROOK I. R. NO. 14, Zone: 2) )
- 3) [Arrested; Charged; Intoxicated; Subject of complaint] PAUL, DEVERON TYRONE 1987/01/23 (24) M (5 POPLAR STREET, Apt. 3, INDIAN BROOK, NS Canada (Div: H, Dist: Indian Brook, Det: Indian Brook, FN reserve: INDIAN BROOK I. R. NO 14, Zone: 3) ), FPS:875537E D

Involved address(es): 1) [Dispatch address; Occurrence address] 76 INGLIS PLACE S, TRURO, COLCHESTER COUNTY NS Canada (CHEVYS) (Dist: EPPA, Det: Truro NS PS, Zone: 1)

Involved vehicle(s):

Involved officer(s):

- 1) #E00001002 GARLAND, M. (Charging officer/unit)
- 2) #E00002254 D'ENTREMONT, K. (Assisting officer; Charging officer/unit)
- 3) #E00000225 REID, K. (Supervising officer)
- 4) #E00002240 GREEN, G. (Charging officer/unit; Lead investigator)
- 5) #E00002563 HICKS, R. (Call taker)
- 6) #E00002718 HUNKA, R. (Charging officer/unit; Lead investigator)
- 7) TRURO NS PS-PLATOON C (Primary unit)
- 8) #E00000236 MACDONALD, J. (Other assisting employee)

Flag(s):

Summary: Cst. Garland Reports over the Radio, that As she was Still on Location at Chevy's, 76 Inglis Place, Truro, N.S., that the Bouncer's Just Threw A Male out the Door, and Because of this, the Male and A Female were Arrested, and Lodged in Cells.....Tasked to Cst. Garland, Assisted by Cst's. D'Entremont, Green, and Hunka.....///// August 28th 2009, both parties arrested contrary to sec 87 (1)LCA. / Deveron Paul also charged under sec.145(3)cc. Parties to be released when sobar by way of SOT. Deveron Paul was remanded into custody pending a hearing pursuant to Section 515. He is to attend Truro Provincial Court September 1, 2009. at 9:30 AM Please review added reports for further details pertaining to this matter, Please conclude. RJH

Remarks:

## Supplementary Occurrence Report

RCMP-GRC/Truro NS PS

Printed: 2009/09/02 07:28 by E00000248

Occurrence: 20091010762 Failure to comply with condition of undertaking or  
recognizance / direction in remand order 145(3) CC (FIP) @2009/08/28 03:00

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Author: #E00002254 D'ENTREMONT, K. Report time: 2009/08/28 03:50  
 Entered by: #E00002254 D'ENTREMONT, K. Entered time: 2009/08/28 03:50  
 Remarks:

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Officers were just clearing from Chevy's for an unrelated call, when Cst. Garland radioed that there was just a guy thrown out by the bouncer and was unsure if he was going to be a problem. Cst. d'Entremont, who had just left seconds ago went back to assist Cst. Garland. When Cst. d'Entremont turned onto Inglis Place, Cst. d'Entremont noted that there was a male sitting on the sidewalk with his shoes behind him, and a female yelling at Cst. Garland. When Cst. d'Entremont went over to assist he was informed by the bouncers that the male appeared to have something in his waistband either a weapon or something of sort. While Cst. Garland was speaking with the male Cst. d'Entremont was trying to keep the female from intervening with the situation at hand. At this time Cst. Green and Cst. Hunka arrived on scene. It was at this time that the female in question attempted to grab the male in trying to get him not to talk to Cst. Garland. Cst. d'Entremont then told the female to let officers do their job and not to intervene with what they are doing. The female then pushed Cst. d'Entremont in order to get at the male, Cst. d'Entremont could smell a strong odour of alcohol coming from her breath, she also had very slurred speech and was unsteady on her feet. Cst. d'Entremont at this time placed her under arrest for being intoxicated in a public place, the female then started to fight with officers. When officers would state stop resisting she would resist more. After a brief struggle the female was taken to the ground in order to get her handcuffed. She was then handcuffed and searched by Cst. Garland and placed in the rear seat of #821. While Cst. d'Entremont and Cst. Garland were struggling with the female Cst. Green and Cst. Hunka were struggling with the male. Both were transported to TPS for Being Intoxicated in a public place, and lodged until sober. SOT's to be issued.

The female was identified as Victoria Rose PAUL, DOB: 1965-09-30. SOT #4127095

The male was identified as Deveron Tyrone PAUL, DOB: 1987-01-23. SOT #4127094

Cst. K. d'Entremont

Truro Police Service

## General Occurrence Report

RCMP-GRC/Trois Rivières

Printed: 2009/09/02 07:29 by E00000246

Occurrence: 20091010762 Failure to comply with condition of undertaking or  
recognizance / direction in remand order 146(3) CC (FIP) @2009/08/28 03:00

Author: #E00001002 GARLAND, M.

Report time: 2009/08/28 20:34

Entered by: #E00001002 GARLAND, M.

Entered time: 2009/08/28 20:39

Remarks:

On August 28th 2009, this writer was just clearing from a call at Chevy's bar, when this writer noted that the bouncers were putting a male out at that location. This writer advised other units of what was taking place and that this writer was going to stay on scene as there may be problems. This writer exited the police vehicle and noted that bar staff were also putting out a female party as well. When the female party saw this writer she put her arm around the male and stated that she was his mother and she was going to take him home, both parties were noted to be of a very intoxicated manner.

This writer was informed by the bouncers that the male party had something in his pants and they also stated that they believed that he was on conditions. It was at this point that writer tried to intervene to speak to with the male. The female party began to yell at this writer stating she was going to take the male home. This writer advised the female that she needed to speak to the male party. The male party then sat on the edge of the sidewalk, this writer noted that there was a huge bulge in the back of the males pants. At that time could not determine what the object was.

Other officers arrived on scene, Cst. d'Entremont accompanied me and I explained to him that there was something in the males pants and also that the bouncers believed that this male was on conditions. At that time, this writer tried to speak to the male, who was highly intoxicated. He was slurry his speech and appeared to have a hard time answering simple questions. While this writer was speaking with to the male, Cst. d'Entremont was trying to keep the female from intervening. Cst. Green and Cst. Hunka arrived on scene. It was at this point that the female tried to get to the male, by pushing Cst. d'Entremont out of the way. Cst. d'Entremont then placed the female under arrest for 87(1) being intoxicated in a public place. See Cst. d' Entremonts Supplementary report for arrest details. The female then began to fight with officers. This writer stepped in to help officers and attempted to handcuff female. Female had to be taken to the ground in order to gain control over her and to cuff her. Once cuffed she was escorted to this writer's PC and transported to Cells.

While officers were dealing with female party, the male party began to fidget, this writer informed Cst. Hunka that the male had something in his pants and at this time this writer was unsure of what the object was. This writer could hear Cst. Hunka requesting that the male keep his hands where they could be seen. Male would not comply with Cst. Hunka's requests. Cst. Hunka then proceeded to

place the male under arrest for 87(1) being intoxicated in a public place. See Cst. Hunka's Supplementary report for arrest details

Both parties were transported to TPS cells and were lodged in cells. The female was identified as Victoria PAUL and the male was her son Deveron PAUL. Victoria PAUL was lodged in cells until sober and was released with a SOT under Section 87(1) of the Liquor Control Act. Deveron PAUL was checked for conditions and is on a Recognizance given by a Justice or Judge, one of the conditions of this Recognizance was not to possess or consume alcohol. He was in breach of this condition as it was noted by officers that he was highly intoxicated.

2009-08-28

Arrived on shift to find that Deveron PAUL has been remanded into custody until September 1, 2009 due to his breach of his Recognizance.

File completed and to be submitted.

NFAN. CH.

Cst. Garland

## Supplementary Occurrence Report

RCMP-GRC/Truro NS PS

Printed: 2009/08/02 07:31 by E00000246

Occurrence: 20091010762 Failure to comply with condition of undertaking or  
recognizance / direction in remand order 145(3) CC (FIP) @2009/08/28 03:00

Author: #E00002718 HUNKA, R.

Report time: 2009/08/28 03:40

Entered by: #E00002718 HUNKA, R.

Entered time: 2009/08/28 03:44

Remarks:

***On August 28th 2009, Cst Garland of TPS advises of an Intoxicated male being thrown out of Chevy's bar located on Inglis Street, Truro.***

Once on scene, writer observed Cst Dentrament speaking with a very intoxicated female and what seemed to be a very intoxicated male seated directly behind the two. Female later identified as Victoria Rose Paul, and male as a Deveron Tyrone Paul. At this time Victoria suddenly became very aggressive with officers and began to resist officers commands. At this time Cst Dentrament proceeded to place Victoria Paul under arrest for Being intoxicated in a public place contrary to sec.87(1) LCA, with assistance from Cst's Green, Hunka, and Garland. Also at this time writer could observe Deveron Paul playing with his waist band even after writer had demanded him to stop for officer and public safety. However Deveron persisted to continue and become very rude with bouncers and declined to obey writers demands. At this time writer proceeded to place Deveron under arrest for being intoxicated in a public place, contrary to sec.87(1)LCA. Please note that while writer placed TPS issued handcuffs on Deveron, Multiple bouncers had to assist as Deveron was quit resistant. Writer could sense a high level of intoxication on Deveron by a strong smell what seemed to be an alcoholic beverage coming from Deveron's breathe and clothing, staggered motor functions and slurred speech.

Once secure and in handcuffs, writer was advised by Bouncers that both Victoria and Deveron had been removed by the bay due to both parties being aggressive within the bar. Also Bouncers stated that Deveron had some type of item stuck within his waist band. At this time writer could feel what seemed to be a pint of alcohol, however writer could not remove the item as it was stuck to his clothing.

Deveron was placed in back of unit 820, while victoria was placed in back of unit 821 with female, Cst Garland. Both parties transported to TPS cells for booking.

At 0310hrs, both unit 820 and 821 arrived at TPS to book involved parties. Cst Garland proceeded to search Victoria Rose Paul while writer searched Deveron Paul. NOTE that writer could not charter and caution Deveron Paul in regards to the s.87(1)LCA charge due to Deveron's level of intoxication. Deveron at times was very slow to respond and at times and uttered statements which were not suitable for the situation as Deveron's main concern was the Pint of Alcohol which had been found in his boxer shorts.

While querying both parties to check for any possible conditions / warrants, writer was advised by Dispatch that Deveron Paul is currently on a Recognizance given by a Justice or Judge with noted condition to not posses or consume any alcoholic beverages. Due to the level of intoxication and the found Captain Morgan Pint, Deveron was in breach of the Recognizance.

At 0432hrs , writer attempted to speak with Deveron Paul in relation to this found recognizance and to charter and caution. However when asked by writer " how are ya feeling Deveron?", Deveron could not respond due to the level of intoxication.

At this time both Victoria Paul and Deveron Paul will be issued a SOT under sec. 87 (1) LCA when released. Also Deveron Paul will be released by way of PTA with a court date of September 30th 2009 to answer before a Judge in relation to the breach of recognizance.

Tasks sent to Ident sections for prints and photos on September 28th 2009, and Hard copy completed.

Respectfully submitted for review by;

Cst R HUNKA / Truro Police Service. / C Platoon





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## **Appendix F**

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## PRISONER REPORT - RAPPORT SUR LE PRISONNIER

☒ Mun. ☐ Prov. ☐ RCMP GRC ☐ Other (specify) Autre (préciser)

Page no. N° de page

Location of event/arrest - Lieu de l'événement/arrestation		Status - État	Surname - Nom de famille		Occurrence no. - N° d'incident
			Paul		89 1010702
Checked - Vérification		Subject no. N° du sujet	G1 - P1	G2 - P2	Sex - Sexe
<input type="checkbox"/> PIRS - SRRJ <input type="checkbox"/> Hit - <input type="checkbox"/> CPIC - CIPC <input type="checkbox"/> Hit -		Address - Adresse			
		505 Chuch Street Tulsa, Okla.			
Type of warrant - Genre de mandat		<input type="checkbox"/> Same as location of event/arrest - Indicate zone Identique au lieu de l'événement/arrest. - Indiquer la zone			
Member - Membre Charier / Init. / Warning / Mise en garde / Init. / Counsel / Avocat / Contacted / Contacté / Init.		Bus. tel. - Tél. bur.		Res. tel. - Tél. rés.	
Det. holding warrant - Dét. détenteur du mandat		DOB - DON	App. age / Age app.	Height / Taille	Mass / Masse
		65/10	34	20	
Prisoner no. - Matr. du prisonnier		Driver's Licence no. - N° de permis de cond.	POI - PDE	Photo no. - N° de photo	Book no. N° d'écrou
Cell no. / N° de cellule		Charge(s) - Accusation(s)		F.P.S.	
<input type="checkbox"/> Young Offender - Jeune contrevenant <input type="checkbox"/> Parole/guardian advised - Père ou mère/tuteur avisés <input type="checkbox"/> YCJA waiver - Renonciation prévue par la LSJPA		Investigator - Enquêteur		Reg. no. - Matr.	
<input type="checkbox"/> Fingerprinted and photographed on / Empreintes et photographié le / par		Nature of event - Genre d'événement		Reported on / Signifié le	
		09.08.20		3:23	
Reg. no. - Matr.		Y-A M D-J	Occurred between / Survenu entre	Y-A M D-J	HH:MM and / et

## CONDITIONS OF RELEASE - CONDITIONS DE LIBÉRATION

507 in the AM.

## DETAILS/ACTION - PRÉCISIONS/MESURES

## AFFECTS - EFFETS (Prisoner signs in shaded areas - Le prisonnier signe dans les cases ombrées)

<input type="checkbox"/> Bankbook / Carnet de banque	<input type="checkbox"/> Glasses / Lunettes	<input type="checkbox"/> Pager / Téléavertisseur	<input type="checkbox"/> Skirt - Jupe	Cash / Argent liquide	Cheques / Chèques
<input type="checkbox"/> Belt / Ceinture	<input type="checkbox"/> Hat - Chapeau	<input type="checkbox"/> Pants - Pantalon	<input type="checkbox"/> Wallet - Portefeuille		
<input type="checkbox"/> Coat - Manteau	<input type="checkbox"/> Jewellery - Bijoux	<input type="checkbox"/> Purse - Sac à main	<input type="checkbox"/> Watch - Montre	Deduct. - Ret.	Bal. - Solde
<input type="checkbox"/> Cell phone / Cellulaire	<input type="checkbox"/> Keys - Clés	<input type="checkbox"/> Radio	<input type="checkbox"/> Other / Autre		
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Lighter - Brique	<input type="checkbox"/> Ring(s) - Bague(s)			
<input type="checkbox"/> Dress - Robe	<input type="checkbox"/> Medication / Médicaments	<input type="checkbox"/> Shirt - Chemise			
<input type="checkbox"/> Earplugs / Bouchons d'oreilles	<input type="checkbox"/> Misc. paper / Papier divers	<input type="checkbox"/> Shoes - Souliers			

Bulky effects - Effets volumineux

Searched by - Fouillé par

## PRISONER SCREENING - EXAMEN DU PRISONNIER

Possible cause of impairment (drugs, liquor, medication, etc.) - Cause possible des troubles anormaux (drogues, alcool, médicaments, etc.)		Unusual Actions (hiccough, belching, vomiting, fumbling, etc.) - Gestes inhabituels (hoquet, rots, vomissements, maladresse, etc.)	
Drugs (other than alcohol) / Drogues (autre que l'alcool)	Responsibility - Réveil / Responsiveness checked / Réactions vérifiées	Injuries - Blessures	Illnesses/medications - Maladies/médicaments
Speech (stutter, slur, slurring, sagging, falling, etc.) - Élocution (stotter, bégayer, trébucher, etc.)	Stable (stable, calm, alert, etc.) - Équilibre (stable, assez stable, équilibré, etc.)	Speech (stutter, incoherent, confused, clear, etc.) - Élocution (indistincte, incohérente, confuse, claire, etc.)	Consciousness (alert, confused, sleepy, etc.) - Conscience (alerte, confuse, somnolente, etc.)
Medication required, unusual characteristics, distinguishing marks, etc. - Médicaments requis, particularités, signes distinctifs, etc.			
<input type="checkbox"/> Drugs - Drogues	<input type="checkbox"/> Escaped - Évadé	<input type="checkbox"/> Protective custody / Protection	<input type="checkbox"/> Violent
<input type="checkbox"/> Emotionally disturbed person / Individu perturbé émotionnellement	<input type="checkbox"/> Not known/observed	<input type="checkbox"/> Suicidal	<input type="checkbox"/> Other / Autre

Medical examination by - Examen médical par

Fit for incarceration / Apté à l'incarcération

DATE AND TIME - DATE ET HEURE

Escorted from - Escorté de

Person taking over - Remis à la charge de

Reason - Raison

BOOKED IN / MIS AUX ÉCROUX

Supervisor signature - Signature du superviseur

NEALS REPAS

MRS. E.

DISTRIBUTION: 1) MASTERFILE - DOSSIER PRINCIPAL 2-4) WORKING FILES - DOSSIERS DE TRAVAIL

## PRISONER REPORT - RAPPORT SUR LE PRISONNIER

☒ Mun. ☐ Prov. ☐ RCMP GRC ☐ Other (specify) Autre (préciser)

Page no. N° de page

Location of event/arrest - Lieu de l'événement/arrestation <i>Ingle Street</i>		Status - État	Surname - Nom de famille <i>Paul</i>		Occurrence no. - N° d'incident <i>69 100762</i>
Checked - Vérification <input type="checkbox"/> PIRS - SRRJ <input type="checkbox"/> Hit - <input type="checkbox"/> CPIC - CIPC <input type="checkbox"/> Hit -		Subject no. - N° du sujet <i>Devered</i>	G1 - P1 <i>Tyrone</i>	G2 - P2	Sex <i>M</i>
Type of warrant - Genre de mandat <input type="checkbox"/> Endorsed Visé		Address - Adresse <i>565 Church Street</i>			
Member - Membre Charter read Chloria Luc		Same as location of event/arrest - Indique zone identique au lieu de l'évén./arrest. - indiquer la zone			
Warning Mise en garde		Bus. tel. - Tél. bur.			
Init.		Res. tel. - Tél. rés.			
Counsel contacted Avocat contacté		DOB - DDN App. age Age app.			
Cod. - Code d'intercl.		Height Taille			
DOB - DDN		Mass Masse			
Hair Cheveux		Eyes Yeux			
Race/desc Race/orig.		POB - LDN			
Prisoner no. - Matr. du prisonnier		Cell no. - N° de cell. <i>Bulph</i>		Bag no. - N° de sac	
Driver's Licence no. - N° de permis de cond.		POI - PDE		Photo no. - N° de photo	
Book no. - N° d'écrou		Charge(s) - Accusation(s) <i>87(1)</i>			
Investigator - Enquêteur <i>Hunka</i>		Reg. no. - Matr.		Unit - Service	
Col. code Code d'intercl.		F.P.S.			
Nature of event - Genre d'événement		Reported on Signalé le		Y-A M D-J HH:MM	
Reg. no. - Matr.		Y-A M D-J		HH:MM	
Occurred between Survenu entre		Y-A M D-J		HH:MM	

CONDITIONS OF RELEASE - CONDITIONS DE LIBÉRATION

*507 in the AM.*

DETAILS/ACTION - PRÉCISIONS/MESURES

EFFECTS - EFFETS (Prisoner signs in shaded areas - Le prisonnier signe dans les cases ombrées)

<input type="checkbox"/> Bankbook - Carnet de banque	<input type="checkbox"/> Glasses - Lunettes	<input type="checkbox"/> Pager - Téléavertisseur	<input type="checkbox"/> Skirt - Jupe	Cash - Argent liquide <i>7.75</i>	Cheques - Chèques
<input checked="" type="checkbox"/> Belt - Ceinture	<input type="checkbox"/> Hat - Chapeau	<input type="checkbox"/> Pants - Pantalon	<input type="checkbox"/> Wallet - Portefeuille	Deduct. - Ret.	Bal. - Solde
<input type="checkbox"/> Coat - Manteau	<input type="checkbox"/> Jewelry - Bijoux	<input type="checkbox"/> Purse - Sac à main	<input type="checkbox"/> Watch - Montre	Reason - Raison	
<input type="checkbox"/> Cell phone - Cellulaire	<input type="checkbox"/> Keys - Clés	<input type="checkbox"/> Radio	<input type="checkbox"/> Other - Autre		
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Lighter - Briquet	<input type="checkbox"/> Ring(s) - Bague(s)	<input type="checkbox"/> Shirt - Chemise		
<input type="checkbox"/> Dress - Robe	<input type="checkbox"/> Medication - Médicaments	<input type="checkbox"/> Shoes - Souliers	<input type="checkbox"/> Socks - Chaussettes		
<input type="checkbox"/> Earrings - Boucles d'oreilles	<input type="checkbox"/> Misc. paper - Papier divers				

Bulky effects - Effets volumineux

Searched by - Fouillé par <i>X.D. [Signature]</i>	
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PRISONER SCREENING - EXAMEN DU PRISONNIER

Possible cause of impairment (drugs, liquor, medication, etc.) - Cause possible des troubles anormaux (drogues, alcool, médicaments, etc.)

Unusual Actions (hiccough, belching, vomiting, fumbling, etc.) - Gestes inhabituels (hoquet, rots, vomissements, maladresse, etc.)

Rousability - Réveil Responsiveness checked Réactions vérifiées

Illnesses/medications - Maladies/médicaments

Speech (stuttered, incoherent, confused, clear, etc.) - Élocution (indistincte, incohérente, confuse, claire, etc.)

Consciousness (alert, confused, sleepy, etc.) - Conscience (alerte, confuse, somnolente, etc.)

Medication required, unusual characteristics, distinguishing marks, etc. - Médicaments requis, particularités, signes distinctifs, etc.

Drugs - Drogues

Escaped - Évadé

Protective custody - Isolement protecteur

Violent

Emotionally disturbed person - Individu perturbé émotionnellement

Not known/observed

Suicidal - Suicidaire

Other - Autre

Medical examination by - Examen médical par

Y-A M D-J HH:MM

Fit for Incarceration - Apte à l'incarcération

Yes - Oui

No - Non

1st Appear - 1re comparution

Acquitted - Acquitté

Committed - Incarcéré

Sentenced - Condamné

DATE AND TIME - DATE ET HEURE (Y-A M D-J HH:MM)

Escorted from - Escorté de

by - par

Unit - Service

Y-A M D-J

Destination

Person taking over - Remis à la charge de

Det. or Inst. - Dét. ou établ.

Y-A M D-J

HH:MM

Y-A M D-J

HH:MM

Reason - Raison

Init.

BOOKED OUT - LEVÉE D'ÉCROU

Reason - Raison

Init.

MEALS REPAID HRS.	MUN.	PROV.	RCMP - GRC	TOTAL	Supervisor signature - Signature du superviseur	Date Y-A M D-J
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RCMP GRC (13-1) (2003-03)

DISTRIBUTION: 1) MASTERFILE - DOSSIER PRINCIPAL 2 - 4) WORKING FILES - DOSSIERS DE TRAVAIL

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## **Appendix G**

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## **Health Care of Prisoners 4R's Observation Guide**

To be used as a tool in assessing the physical state of prisoner prior to being placed in cells. If prisoner fails to pass any of the following criteria ambulance must be called. When in doubt call ambulance.

1. **Rousability** : Can the prisoner be woken ?
2. **Response** : Can they give appropriate answers to questions such as
  - What is your name ?
  - Where do you live ?
  - Where do you think you are ?
3. **Response to Commands** - can they respond appropriately
  - Open your eyes
  - Lift your arm etc.
4. **Remember** - keep in mind the possibility of another illness
  - Diabetes
  - Epilepsy
  - Head injury
  - Alcohol or drug overdose
  - Stroke

**WHEN IN DOUBT CALL AN AMBULANCE**

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## **Appendix H**

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# TRURO POLICE SERVICE

## CELL CHECK

(CELL TO BE CHECKED PRIOR TO USE)

OCC.#: 2009-1010762

CELL #: 7

INMATE'S NAME: Victoria Rose Paul

CLEANLINESS	YES	NO	COMMENTS
FLOOR	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
WALLS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
CEILING	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
BUNK	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
BARS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
FREE OF FOREIGN OBJECTS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

SERVICEABILITY	YES	NO	COMMENTS
TOILET	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
FOUNTAIN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
HEAT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
SPRINKLER HEAD	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
DOOR	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
LIGHT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
CAMERA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

### MEALS


2009-09-02

and for file 4 pps

S/Sgt. [Signature]

GUARD (PRINT)

Conn Clyde

INMATE

Conn Clyde

DATE / TIME

28 Aug. 2009 1509 hrs

**ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES**

TPS

Page 1 of 3

Name: Victoria Rose Paul	Occurrence Number: 09-1010762
Date: 28 August 2009	Cell No: 7 Bln: 7 Bag: 7

TIME:	COMMENTS	Init
0309	Cell is clean and clear of foreign objects ———	gc
0310	Cst. Hunka and Cst. Garland brought prisoner into cell area. Cst. D'Entremont in cell area to assist. ———	gc
0312	Cst. Hunka is holding prisoner still while Cst. Garland searches her. ———	gc
0315	Placed in cell by Cst. D'Entremont, Cst. Garland, Cst. Hunka and Cpl. Reid in to assist. ———	gc
0345	Missed check due to processing prisoner. Laying on right side. Seen breathing. ———	gc
0400	Laying on left side. Seen breathing. ———	gc
0415	Laying on left side. Seen breathing. ———	gc
0430	Laying on left side. Seen breathing. ———	gc
0445	Laying on right side. Seen breathing. ———	gc
0500	Laying on right side. Moved hand. ———	gc
0515	Laying on right side. Seen breathing. ———	gc
0530	Laying on right side. Seen breathing. ———	gc
0545	Laying on left side. Seen breathing. ———	gc
0600	Laying on left side. Seen breathing. ———	gc
0615	Laying on left side. Seen breathing. ———	gc
0630	Laying on left side. Seen breathing. ———	gc
0638	Laying on floor crying. Asked if she was OK she said No. Asked what was wrong she refused to answer. ———	gc
0645	LAYING ON FLOOR CRYING. ———	gc

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**ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES**

Page 2 of 3

Name: <u>VICTORIA ROSE PAUL</u>	Occurrence Number: <u>09 1010764</u>
Date: <u>28 AUGUST 2009</u>	Cell No: <u>7</u> Bln: <u>7</u> Bag: <u>7</u>

TIME:	COMMENTS	Init
0700	LAYING ON FLOOR. ASKED THE TIME	01
0715	LAYING ON FLOOR. MOVING	01
0730	LAYING ON FLOOR. MOVING	01
0745	LAYING ON FLOOR. MOVING	01
0800	LAYING ON FLOOR. MOVING AND <del>YELLING</del>	01
0810	UNABLE TO BE CONCRENT	01
0813	CALLED DUTY SGT	01
0817	SAT HENDERSON AND CPT HICKOX ARRIVED THEY CALLED	01
	IN CPT MANUEL FOR ASSISTANCE. TRIED GETTING	01
	PRISONER UP. LAID HER ON BANK. MOVED HER BACK TO	01
	FLOOR TO PREVENT A FALL. SGT HENDERSON SUGGESTED	01
	MORE FREQUENT CHECKS	01
0845	WOKE PRISONER TO GET A VERBAL RESPONSE	01
	PRISONER LESS VOCAL. HAS PISSED HER PANTS	01
0852	ON FLOOR GROWING	01
0900	ON FLOOR TRIED TO WAKEN - GOT A GROAN AND MOVEMENT	01
0915	LAYING ON FLOOR. MOVING	01
0930	LAYING ON FLOOR. MOVING AND GROWING	01
0945	LAYING ON FLOOR SNORING - TRIED TO WAKEN AND GOT	01
	SOME MOVEMENT AND A GROAN	01
1000	LAYING ON FLOOR. SNORING - ONLY RESPONSE TO AWAKEN	01
	WAS ARM MOVEMENT AND A GROAN.	01
1010	LAYING ON BACK ON FLOOR SNORING, SOME MOVEMENT	01

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**ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES**

Page 3 of 3

Name: <u>VICTORIA ROSE PAUL</u>	Occurrence Number: <u>CR-1010764</u>
Date: <u>28 AUGUST 2009</u>	Cell No: <u>7</u> Bm: <u>7</u> Bag: <u>7</u>

TIME:	COMMENTS	Init
10:22	LAYING ON FLOOR. SNORING AND GROANING	AP
10:30	LAYING ON FLOOR. SNORING, GROANING, MOVING ARMS	AP
10:38	LAYING ON FLOOR. SNORING. ONLY RESPONSE TO WAKE-UP ATTEMPT WAS A GROAN	AP
10:45	LAYING ON FLOOR. MOVEMENT AND GROANS	AP
11:00	LAYING ON FLOOR. HAS ROLLED ONTO STOMACH. STILL GROANING	AP
11:15	LAYING ON STOMACH ON FLOOR. MOVED LEGS	AP
11:30	LAYING ON STOMACH ON FLOOR. MOVED LEGS AND HEAD	AP
11:45	LAYING ON STOMACH ON FLOOR. MOVED LEGS AND GROANS	AP
12:00	LAYING ON STOMACH ON FLOOR. SOME MOVEMENT	AP
12:17	SGT HENDERSON IN TO SEE PRISONER	AP
12:30	LAYING ON STOMACH ON FLOOR. LITTLE RESPONSE	AP
12:37	TRIED TO AROUSE PRISONER. COULD ONLY GET A GROAN	AP
12:47	LAYING ON <sup>STOMACH</sup> <del>STOMACH</del> SIDE. OBSERVED BREATHING	AP
13:01	LAYING ON <sup>STOMACH</sup> <del>STOMACH</del> SIDE. COMM WHITE IN WITH HER	AP
13:05	SGT HENDERSON AUTHORIZED A CALL TO EMS	AP
13:16	EMS ARRIVED	AP
13:32	PATIENT TRANSPORTED TO HOSPITAL - SUSPECTED ALL POISONING. CPT HICKOX ESCORTED	AP
13:41	CPT HICKOX GIVEN PRISONER'S POSSESSIONS	AP

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# TRURO POLICE SERVICE

## CELL CHECK

(CELL TO BE CHECKED PRIOR TO USE)

OCC.#: 2009-1010762

CELL #: 5

INMATE'S NAME: Devereaux Tyrone Paul

CLEANLINESS	YES	NO	COMMENTS
FLOOR	✓		
WALLS	✓		
CEILING	✓		
BUNK	✓		
BARS	✓		
FREE OF FOREIGN OBJECTS	✓		

SERVICEABILITY	YES	NO	COMMENTS
TOILET	✓		
FOUNTAIN	✓		
HEAT	✓		
SPRINKLER HEAD	✓		
DOOR	✓		
LIGHT	✓		
CAMERA	✓		

MEALS


GUARD (PRINT) Conn Clyde

12/19/19

**ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES**

T/S

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Name: <u>Dereem Tyre Paul</u>	Occurrence Number: <u>09-1010762</u>
Date: <u>28 August 2009</u>	Cell No: <u>5</u> Bln: <u>5</u> Bag: <u>5</u>

TIME:	COMMENTS	Init
0309	Cell is clean and clear of foreign objects	gc
0321	Cst. Green brought prisoner into cell, Cst. Hunka is	
	searching him with Cst. D'Entremont assisting.	gc
0326	Cpl. Reid is doing paperwork.	gc
0330	Placed in cell by Cst. Hunka, Cst. D'Entremont, and Comm	
	Clyke	gc
0345	Standing by cell doors Yelling at another prisoner	gc
0400	Laying on back. Seen breathing.	gc
0415	Laying on back. Seen breathing.	gc
0430	Laying on back. Heard snoring.	gc
0445	Laying on left side. Seen breathing.	gc
0500	Laying on left side. Seen breathing.	gc
0515	Laying on left side. Seen breathing.	gc
0530	Laying on left side. Moved arm.	gc
0545	Laying on left side. Seen breathing.	gc
0600	Laying on left side. Seen breathing.	gc
0615	Laying on left side. Wiping face with hands.	gc
0630	Standing by cell door asked for a blanket. Sgt. Henderson	
	OK'd blanket.	gc
0645	LAYING ON LEFT SIDE. OBSERVED BREATHING	gc
0700	LAYING ON LEFT SIDE. OBSERVED BREATHING	gc
0715	LAYING ON LEFT SIDE. OBSERVED BREATHING	gc
0730	LAYING ON LEFT SIDE. OBSERVED BREATHING	gc

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**ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES**

Page 2 of       

Name: <u>DEVEREUX TYRONE PAUL</u>	Occurrence Number: <u>09-1010762</u>
Date: <u>28 AUGUST 2005</u>	Cell No: <u>5</u> Bin: <u>5</u> Bag: <u>5</u>

TIME:	COMMENTS	Init
0745	LAYING ON LEFT SIDE OBSERVED BREATHING	AL
0800	LAYING ON LEFT SIDE OBSERVED BREATHING	AL
0815	LAYING ON LEFT SIDE OBSERVED BREATHING	AL
0830	LAYING ON LEFT SIDE OBSERVED BREATHING	AL
0836	TOOK BREAKFAST ORDER AND ORDERED	AL
0845	YELLING AT GUARD	AL
0853	COMPLETED MEDICAL INFORMATION TRANSFER FORM	AL
0900	GIVEN BREAKFAST	AL
0915	STANDING AT BARS	AL
0930	STANDING AT BARS - YELLING FOR HIS MOTHER	AL
0945	STANDING AT BARS - YELLING FOR HIS MOTHER	AL
0948	GIVEN TOILET PAPER	AL
1000	PRISONER ASKED TO SPEAK WITH A LAWYER	AL
1002	SGT ADVISED OF REQUEST. WILL BE DONE SHORTLY	AL
1003	PRISONER ADVISED	AL
1015	LAYING ON RIGHT SIDE OBSERVED BREATHING	AL
1030	LAYING ON RIGHT SIDE OBSERVED BREATHING	AL
1045	LAYING ON STOMACH OBSERVED BREATHING	AL
11:00	LAYING ON STOMACH OBSERVED BREATHING	AL
11:05	ADVISED HIM HE WOULD NOT BE GOING TO COURT IN A NEW	AL
	GLASGOW TODAY. FIERCE AND BURNING SOUGHT. ASKED AGAIN TO	AL
	SPEAK WITH LAWYER.	AL
11:15	LAYING ON LEFT SIDE. ASKED AGAIN TO SPEAK WITH A LAWYER	AL

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**ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES**

Page 1 of 1

Name: <u>DEVEREUX TYRON PAUL</u>	Occurrence Number: <u>09-1010760</u>
Date: <u>28 AUG 2009</u>	Cell No: <u>5</u> Bin: <u>5</u> Bag: <u>5</u>

TIME:	COMMENTS	Init
11:25	CST DENSMORE AND MANUEL TALKING WITH PRISONER	AD
11:30	LAYING ON RIGHT SIDE OBSERVED BREATHING	AD
11:39	TAKEN TO PHONE ROOM BY GUARD AND CST MANUEL	AD
11:49	RETURNED TO CELL	AD
11:50	TOOK LUNCH ORDER	AD
12:00	LAYING ON RIGHT SIDE. OBSERVED BREATHING	AD
12:15	LAYING ON RIGHT SIDE. OBSERVED BREATHING	AD
12:31	LAYING ON STOMACH. OBSERVED BREATHING	AD
12:38	SPOKE TO PRISONER ABOUT HIS MOTHER. SHE CONSUMED	AD
	OVER 12 BEER AND 1 QUART OF RUM - MINIMUM SHE	AD
	IS TO HAVE SURGERY NEXT WEEK	AD
12:45	LAYING ON RIGHT SIDE. OBSERVED BREATHING	AD
13:00	LAYING ON LEFT SIDE. TALKED WITH GUARD	AD
13:01	TALKED TO DISPATCH <del>ENTERED ON WRONG SHEET</del>	AD
13:01	COMM. W/ GUARD IN WITH PRISONER <del>ENTERED ON WRONG SHEET</del>	AD
13:15	LAYING ON BUNK. TALKED WITH GUARD	AD
13:40	DELAYED DUE TO MEDICAL EMERGENCY. TALKED WITH PRISONER	AD
13:45	ORDERED MEAL FOR PRISONER <del>ADVISED DISPATCH</del>	AD
13:51	CST DENSMORE AND MANUEL TOOK PRISONER TO PHONE ROOM	AD
14:27	PRISONER RETURNED TO CELL AND GIVEN LUNCH	AD
14:31	PRISONER TALKED TO GUARD	AD
14:35	CST MANUEL TALKING TO <del>ENTERED</del> PRISONER	AD

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ALL PERSONS IN LOCKUP WILL BE CHECKED EVERY  
15 MINUTES

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Name: <u>DEKRAH TYRONA PAUL</u>	Occurrence Number: <u>09 1010762</u>
Date: <u>AUG 28/09</u>	Cell No: <u>5</u> Bin: <u>5</u> Bag: <u>5</u>

[illegible]

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## **Appendix I**

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MUNICIPAL/RCMP - LOCKUP REPORT	
	Roy Kennedy, Policing Strategy Branch, Department of Justice
Location of building	
Type of building	
Accommodation type	
Number of levels	
Location of lockup in building	
No. of cells	
Ceiling	
Walls	
Floor	
Adequate/safe storage	
Access to lockup	
Ventilation	
Sally Port on cells	
Cell doors	
Sitting/sleeping	
Toilet/sink	
Lighting	
Windows	
Exposed support for ligatures in cells	
Floor drains	
Segregated cells	
Keyed alike cells	
Release type	
Key-lock Maintenance Program	
Generator	
Type	
Auxiliary services supported	
Emergency lighting	
Tested	
Adequate perimeter lighting	

15 Minute (Physical) Checks	
Recorded/Documented/Verified by Duty NCO	
C.C.T.V.	
How many?	
Appropriately located in cells & entrance way	
Monitored persons in custody checks	
Continuous record/stored	
Proof they are working	
How often checked	

Log books kept	
CPIC check confirmed	
Recorded information	
Person in custody property reports	
Items described	
Initialed by Shift Supervisor (Municipal Agencies)	

Is the Administration accommodation adequate	
Is the furniture & equipment adequate	
Is the sys. of facility intercom. Adequate	

Permitted telephone access	
Record kept of all calls in/out	
Private use (Solicitor, etc.)	
Children's Ombudsman contact information posted for youth offenders	
Feminine Hygiene products available	

Adequate communication to police	
Staff telephone list available	
Response to unusual situations	
Additional restraint equipment available	
Fire drills performed	

Day Shift/Night Shift complement	
Appropriate gender supervising/monitoring	
Only appropriate staff in cell block area	
Annual performance evaluation process for custodians	

Contain adequate direction to staff	
Available to on-duty staff	
Record confirming copy issued to each guard/matron or signed for	
Smoking policy	
Smoking policy enforced	

Facility inspected regularly	
Cleaning-Are cells cleaned after each use	
Documented	
Hazardous spills supplies	
Cells inspected after each use	

Reinspection required by Fire Marshall	
Fire alarm system throughout building	
Smoke detectors in cell area	
Thermal detectors/sprinklers in other areas	
Fire alarm sprinkler system maintained	
Fire alarm system connected to local fire dept.	
Fire orders/evacuation route maps posted	
Facility equipped with 1 1/2" standpipe c/w hose and fog nozzle	
Will hose reach all cells	
Fire extinguisher placed appropriately	
Fire extinguisher properly maintained	

**Medical Services**

Storage adequate/safe	
Supervision/security storage area adequate	
First Aid kits stocked & maintained	
Staff aware of kit's location	
Proper signage posted	
Adequate safety/protective equipment available to staff and persons in custody	
Medical services available	
On-site medical evaluation available	
Cleaning/maintenance staff	

**Training**

Lockup staff trained in First Aid/CPR	
Is training current	
Certificates on file	
Orientation training provided	
Includes duties & job description	
Fire prevention training	
Fire extinguisher training	
WHIMS training	
Refresher/ongoing training	
Drug Recognition Chart or equivalent	
Note Taking	
Suicide Intervention	
Use of Force	

**Property**

Is Property form completed	
Are items adequately described	
Security & control of personal property	

**Person in Custody**

Person in Custody escape	Yes <input type="checkbox"/> No <input type="checkbox"/>
Investigations of significance	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lockup Inspector notified of In-Cell Death.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Admitting persons in custody	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medication	Yes <input type="checkbox"/> No <input type="checkbox"/>
Refusing to admit for medical and health reasons	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Risk Person in Custody	Yes <input type="checkbox"/> No <input type="checkbox"/>
CPIC/In house check	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are all guards/matrons knowledgeable of all policies/procedures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is this verified by the Supervisor	Yes <input type="checkbox"/> No <input type="checkbox"/>
Feeding persons in Custody	Yes <input type="checkbox"/> No <input type="checkbox"/>
Visiting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Release of persons in custody	Yes <input type="checkbox"/> No <input type="checkbox"/>
Release of information	Yes <input type="checkbox"/> No <input type="checkbox"/>
Non-release of persons in custody	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bomb threat	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medical staff/facility	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Comments:**

**Recommendations:**

**Suggestions:**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**H. Roy Kennedy  
Lockup Inspector  
Public Safety Division, Policing Strategy Branch  
Department of Justice**

